

## REQUEST FOR PROPOSALS (RFP)

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Acquisition Title: **RFP #0634-202 E2SHB 1290 Procurement**

Summary of Expected Results: The Department of Social and Health Services will select qualified bidders to provide community mental health programs that help people experiencing mental illness to retain a respected and productive position in the community.

Proposal Due Date: All proposals, whether mailed or hand delivered, must be received at the following address by 3:00 p.m. local time, May 31, 2006.

**Faxed or electronically mailed proposals will not be accepted.**

Submit Proposal to: Andrew Kramer, RFP Coordinator  
Department of Social and Health Services  
Administrative Services Division, Central Contract Services

Mailing Address: P.O. BOX 45320  
Olympia, Washington 98504-5320

Physical Address: 1115 Washington Street  
Olympia, Washington 98504-5320

Telephone: (360) 664-6073

FAX: (360) 664-6184

Email: [rsnprocurement@dshs.wa.gov](mailto:rsnprocurement@dshs.wa.gov)

Reference: RFP #0634-202 E2SHB 1290 Procurement

Bidder Eligibility: This solicitation is open to entities that are able to provide managed behavioral health services on an at risk basis and are one of the following:

1. Currently contracted as an RSN; or
2. One or more Washington Counties; or,
3. A non-profit entity that meets the risk reserve requirements of section 1.3.

Special Notes: Bidders who do not meet these minimum qualifications shall be deemed non-responsive and will not receive further consideration. Bidders are responsible for accessing the RFP document through the MHD procurement web site [http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml) and are responsible for checking the site for any future notifications, amendments, etc. All Bidders who wish to participate must be able to communicate with the RFP Coordinator via e-mail.

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## **EXHIBITS:**

**Exhibit A – Bidder Information, Certifications and Assurances Form**

**Exhibit B – Model PIHP Contract**

**Exhibit C – Model State-funded Contract**

**Exhibit D – Checklist for Responsiveness**

**Exhibit E – Fiscal Information**

**Exhibit F – Scoring Tool**

## **1. INTRODUCTION**

### **1.1. Background**

The Washington State Legislature passed the County-Based Mental Health Services Act, Laws of 1989, Ch. 205, to create a single point of local responsibility for Mental Health services. This legislation created county-based RSNs to design and administer Mental Health delivery systems to meet the unique needs of people with mental illness. Although the RSNs addressed the issue of coordination of outpatient and state hospital care, prior to 1993 they did not have the responsibility to manage care and to control the escalating costs of the Medicaid program.

The Mental Health Division (MHD) began delivering Mental Health services in 1993 under a 1915(b) waiver in 1993, for outpatient Mental Health services. The capitated, managed Mental Health system gives a RSN the ability to design an integrated system of Mental Health care and, as necessary, subcontract with a network of Community Mental Health Agencies (CMHAs) capable of providing quality service delivery which is age and culturally competent. Establishing capitated managed care gave the State the ability to control the rate of financial growth and improve Mental Health service outcomes. The Mental Health services covered under the waiver were the full range of community Mental Health rehabilitation services offered under the Medicaid State Plan through a fee-for-service (FFS) reimbursement system. The Mental Health services stress ongoing community support to provide the enrollee with tailored services that are responsive to their individualized needs.

In 1997, an amendment to the existing waiver was approved, which incorporated community psychiatric inpatient services for Medicaid eligible adults, older persons, and children into the capitated contracts with the RSNs. An essential component of the waiver amendment was to provide the RSNs the first opportunity to demonstrate qualifications and enter into an integrated full-risk capitated Mental Health services contract with MHD. MHD took this approach due to the existing unique structure of Mental Health and human service delivery systems administered by counties and the RSNs under State law. Pursuant to the Community Mental Health Services Act (RCW 71.24), the RSNs administer all community Mental Health services funded by the State. Under the Involuntary Treatment Act (RCW 71.05), the RSNs are responsible for evaluating and detaining people who are in need of involuntary treatment.

In 2005, the Washington State Legislature mandated the issuance of an RFQ. The intent of this RFQ was to identify qualified RSNs, improve the quality and accountability of the Mental Health system and promote the vision of recovery for people with mental illness.

DSHS/MHD's vision is that all people in the State of Washington who experience mental health challenges will lead happy, productive and fulfilling lives, free of

stigma, in a safe and least restrictive environment. The mental health system will be consumer-driven; mental health will be understood as an essential element of overall health, and a condition from which people can and do recover.

In this vision, mental illness emerges from the shadows of stigma and ignorance to a place of greater public understanding. This understanding transcends cultural difference because it is informed by an array of diverse cultural practices. Mental health services are transformed as consumer experiences systematically and continually guide the system. The following guidelines will drive changes to the mental health system:

- Mental Health services must be based on the principles of wellness and recovery, and place consumers and families at the center of all State efforts of system change and improvements.
- The stigma of mental illness will be reduced and recovery will be possible for all consumers.
- Evidence-based practices will be implemented, and the wellness/recovery model will be integrated into culturally-competent, individualized service plans.
- All policies and programs will ensure that continuity, alignment, and quality of care occur.

The RFQ process completed in January 2006 resulted in qualification of nine of the 14 existing RSNs. The following Service Areas are not being procured through this RFP:

1. King County RSN
2. Clark County RSN
3. Southwest RSN (Cowlitz County)
4. North Central RSN (Adams, Grant and Okanogan Counties)
5. Pierce County RSN
6. Timberlands RSN (Lewis, Pacific and Wahkiakum Counties)
7. North Sound RSN (Island, San Juan, Skagit, Snohomish and Whatcom Counties)
8. Chelan/Douglas RSN (Chelan and Douglas Counties)
9. Greater Columbia RSN (Asotin, Benton, Columbia, Franklin, Garfield, Kittitas, Klickitat, Skamania, Walla Walla, Whitman and Yakima Counties)

## **1.2. Purpose of Request for Proposals**

The State of Washington, Department of Social & Health Services (DSHS), is initiating this Request for Proposals (RFP) in accordance with RCW 71.24.320.

DSHS is initiating this RFP to solicit proposals from entities interested in operating managed care programs that administer services for Title XIX enrollees and for persons eligible for State-funded services and specifically:

- i. Promote the involvement of persons with mental illness, their family members, and advocates in designing and implementing Mental Health services.
- ii. Reduce unnecessary hospitalization and incarceration.
- iii. Improve the quality of services available and promote resilience, rehabilitation, recovery and reintegration and employment of persons with mental illness.
- iv. Increase access to evidence-based, research-based, consensus-based, and promising practices.
- v. Improve collaboration with chemical dependency and criminal justice systems.
- vi. Improve the accountability of the Mental Health system to ensure that funds appropriated by the Legislature are expended for the purpose intended.

RCW 71.24 requires that a Request for Proposals be issued on March 1, 2006 for the following RSN Service Areas:

1. Grays Harbor County RSN
2. Northeast RSN (Ferry, Lincoln, Pend Oreille and Stevens Counties)
3. Peninsula RSN (Clallam, Jefferson and Kitsap Counties)
4. Spokane County RSN
5. Thurston/Mason RSN (Thurston and Mason Counties)

A map of the existing RSNs and the counties the Service Areas can be found on the RSN Procurement webpage

[http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml)

A bidder may bid on one or more of the five RSN Service Areas listed above, however regardless of how many Service Areas a bidder chooses to bid on, only one proposal is to be submitted. In any event, no Bidder may be awarded more than three of the current regions. DSHS reserves the right to offer a bidder a contract to serve as the RSN for any or all of the Service Areas contained in the Bidders proposal.

### **1.3. Minimum Qualifications for Submission of a Proposal**

This solicitation is open to entities that are able to provide managed behavioral health services on an at risk basis and is one of the following:

1. Currently contracted as an RSN; or
2. One or more Washington Counties; or,
3. A non-profit entity.

To be eligible, a Bidder that is a non-profit entity must demonstrate that it has a Risk Reserve in the amount calculated by adding the Estimated Risk Reserve Requirement amounts listed on Exhibit E for each of the Service Areas bid upon. If the Bidder bids on more than three areas then the amount required is the sum of the three highest Estimated Risk Reserve Requirement amounts for the Service Areas bid upon.

Bidders who do not meet these minimum qualifications shall be deemed non-responsive and will not receive further consideration.

#### **1.4. Funding Limitations**

The Secretary of DSHS or her delegate is the only individual who may legally commit DSHS to the expenditure of funds for a contract resulting from this RFP. No cost chargeable to the proposed contract may be incurred before receipt of a fully executed contract.

Any contract awarded as a result of this procurement is contingent upon the availability of funding.

Final Fiscal consideration will be established in the 2006 Washington Legislative session and updated information will be provided when final. Exhibit E provides the estimated funding levels based on the current configuration of RSNs.

#### **1.5. Americans With Disabilities Act**

DSHS complies with the Americans with Disabilities Act (ADA). Bidders may contact the RFP Coordinator to receive this RFP in an alternate format.

#### **1.6. Nondiscrimination**

No individual shall be excluded from participation in, denied the benefits of, subjected to discrimination under, or denied employment in the administration of or in connection with any program provided by this contract because of race, color, creed, marital status, religion, sex, sexual orientation, national origin, Vietnam Era, or disabled veterans status, age, the presence of any sensory, mental, or physical disability, or political affiliation or belief. The prohibition against discrimination in employment shall not apply if the particular disability prevents the individual from performing the essential functions of his/her position, with reasonable accommodations.

## 1.7. Definitions

The following terms which appear in this RFP have the meaning that is defined below:

- 1.7.1. “Action” means, in the case of a PIHP, the denial or limited authorization of a requested service, including the type or level of service; the reduction, suspension, or termination of a previously authorized service; the denial in whole or in part, of payment for a service; the failure to provide services in a timely manner, as defined by the DSHS; or the failure of a PIHP to act within the timeframes provided in section 42 CFR 438(b).
- 1.7.2. “Apparently Successful Bidder (ASB)” means a Bidder who is selected to be offered a contract to perform the services described in this RFP based on the evaluation of the Bidder’s proposal. A Bidder is considered an “apparently” successful Bidder until a contract is finalized and executed.
- 1.7.3. “Appeal” means a request for review of an action as “action” is defined above.
- 1.7.4. “Available Resources” means funds appropriated for the purpose of providing community Mental Health programs, federal funds, except those provided according to Title XIX of the Social Security Act, and State funds appropriated under chapter 71.24 RCW or chapter 71.05 RCW by the legislature during any biennium for the purpose of providing residential services, resource management services, community support services, and other Mental Health services. This does not include funds appropriated for the purpose of operating and administering the State psychiatric hospitals, except as negotiated according to RCW 71.24.300(1)(d).
- 1.7.5. Business Days and Hours: For the purpose of this proposal means Monday through Friday, 8:00 a.m. to 5:00 p.m., Pacific Time, except for holidays observed by the State of Washington.
- 1.7.6. “Care Manager” means a staff person of the RSN that manages access to referrals, care authorization, care coordination, utilization review, and resource management.
- 1.7.7. “CFR” means the Code of Federal Regulations. All references in this Agreement to CFR chapters or sections shall include any successor to the referenced regulation.

- 1.7.8. "Child" means a person who has not reached his/her eighteenth birthday. For persons eligible for the Medicaid program, child means a person who has not reached his/her twenty-first birthday. ~~"Child" means a person under the age of 18 years.~~
- 1.7.9. "Chronically Mentally Ill Adult" means an adult who has a mental disorder and meets at least one of the following criteria: (a) Has undergone two or more episodes of hospital care for a mental disorder within the preceding two years; or (b) Has experienced a continuous psychiatric hospitalization or residential treatment exceeding six months' duration within the preceding year; or (c) Has been unable to engage in any substantial gainful activity by reason of any mental disorder which has lasted for a continuous period of not less than twelve months.
- 1.7.10. "Community Mental Health Agency (CMHA)" means community Mental Health centers that are subcontracted by the PIHP and licensed to provide Mental Health services covered under this RFP and exhibits.
- 1.7.11. "Community Support Services" means services authorized, planned, and coordinated through resource management services, including, at a minimum, assessment, diagnosis, emergency crisis intervention available 24 hours, 7 days a week, prescreening determinations for mentally ill persons being considered for placement in Skilled Nursing Facilities as required by federal law, screening for patients being considered for admission to residential services, diagnosis, and treatment for acutely mentally ill and severely emotionally disturbed children discovered under screening through the federal Title XIX early and periodic screening, diagnosis, and treatment program, investigation, legal, and other nonresidential services under RCW 71.05, case management services, psychiatric treatment including medication supervision, counseling, psychotherapy, assuring transfer of relevant patient information between service providers, recovery services, and other services determined by regional support networks.
- 1.7.12. "Consensus-based" means a program or practice that has general support among treatment providers and experts, based on experience or professional literature, and may have anecdotal or case study support, or that is agreed but not possible to perform studies with random assignment and controlled groups.
- 1.7.13. "Consumer" means a person who has applied for, is eligible for, or who has received Mental Health services. For a child, under the age of 13 or for a child age 13 or older whose parents or legal guardians are involved in the treatment plan, the definition of consumer includes parents or legal guardians.

- 1.7.14. “Contractor” means an organization whose proposal has been selected by DSHS’ evaluation process and is awarded a formal written contract to provide the services that are the subject of this RFP
- 1.7.15. Data Dictionary – Refers to the MHD-CIS Data Dictionary contains the description and definition of Mental Health Consumer data required by the MHD. It includes the transaction formats and technical reporting process for HIPAA encounters and other consumer related data.
- 1.7.16. “Designated Mental Health Professional” means a mental health professional designated by the county or other authority authorized in rule to perform duties specified in RCW 71.24, RCW 71.34 and RCW 71.05.
- 1.7.17. “DSHS” means the Department of Social and Health Services.
- 1.7.18. “Emerging Best Practice” or “Promising Practice” means a practice that presents, based on preliminary information, potential for becoming a research-based or consensus-based practice.
- 1.7.19. “Enrollee” means a Medicaid recipient.
- 1.7.20. “EPSDT” means the Early Periodic Screening Diagnosis and Treatment program under Title XIX of the Social Security Act, as amended.
- 1.7.21. “Evidence-based” means a program or practice that has had multiple site random controlled trials across heterogeneous populations demonstrating that the program or practice is effective for the population.
- 1.7.22. “Fair Hearing” means an “adjudicative proceeding” as defined in RCW 34.05.010(1).
- 1.7.23. “Family” means those the consumer defines as family or those appointed/assigned (e.g., parents, foster parents, guardians, siblings, caregivers, and significant others).
- 1.7.24. “Grievance System” means the overall system that includes processes for grievance and appeals handled at the RSN level and access to the State fair hearing process.
- 1.7.25. “In-Residence Census” (IRC) means the total number of voluntary and involuntary consumers, regardless of where in the State hospital they are housed. Consumers who are committed to the State hospital under RCW 10.77 are not included in the IRC. Consumers who are committed by municipal or district court judges after failed competency restoration

are considered committed under RCW 10.77 until a petition for 90 day civil commitment under RCW 71.05 has been filed in court.

- 1.7.26. "Large Rural Area" means areas with a population density of less than 20 people per square mile.
- 1.7.27. "Medical Necessity" or "Medically Necessary" means a term for describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent the worsening of conditions in the recipient that endanger life, or cause suffering or pain, or result in illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction, and there is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the person requesting service. "Course of treatment" may include mere observation or, where appropriate no treatment at all. Additionally, the individual must be determined to have a mental illness covered by Washington for public Mental Health services. The individual's impairment(s) and corresponding need(s) must be the result of a mental illness. The intervention is deemed to be reasonably necessary to improve, stabilize or prevent deterioration of functioning resulting from the presence of a mental illness. The individual is expected to benefit from the intervention. Any other formal or informal system or support cannot address the individual's unmet need.
- 1.7.28. "Mental Health Care Provider (MHCP)" means the individual with primary responsibility for implementing an individualized service plan for Mental Health rehabilitation services.
- 1.7.29. "Mental Health Division (MHD)" means the division of DSHS under the Health and Recovery Services Administration (HRSA) responsible for oversight of Mental Health services provided through this RFP.
- 1.7.30. "Mental Health Professional (MHP)" means:
  - 1.7.30.1. A psychiatrist, psychologist, psychiatric nurse or social worker as defined in chapters RCW71.05 and RCW71.34.
  - 1.7.30.2. A person with master's degree or further advanced degree in counseling or one of the social sciences from accredited college or university. Such person shall have, in addition, at least two years of experience in direct treatment of persons with mental illness or emotional disturbance, such experience gained under the supervision of mental health professionals.
  - 1.7.30.3. A person who meets the waiver criteria of RCW 71.24.260.

- 1.7.30.4. A person who had an approved waiver to perform the duties of a mental health professional that was requested by the Regional Support Network and granted by the Mental Health Division prior to July 2001.
- 1.7.30.5. A person who has been granted a time limited exception of the minimum requirements of a mental health professional by the mental health division consistent with WAC 388-865-0265.
- 1.7.31. "Proposal" means all material prepared and assembled by a Bidder, and submitted in proposal to this RFP.
- 1.7.32. "Protest" means an objection by the Bidder, in writing, protesting the results of this RFP and which complies with all requirements of this RFP.
- 1.7.33. "RFP Coordinator" means the person named in this RFP as the RFP Coordinator, or the RFP Coordinator's designee within Central Contract Services and the sole point of contact within DSHS regarding this RFP for Bidders and other interested parties.
- 1.7.34. "RFP" means the Request for Proposals, i.e., this RFP document. The RFP is used as a solicitation document in this procurement, as well as all amendments and modifications thereto. The RFP is a documented, formal procurement process providing Bidders an equal and open opportunity to respond to the requirements Stated in the RFP.
- 1.7.35. "RCW" means Revised Code of Washington. All references to RCW chapters or sections shall include any successor to the referenced statute.
- 1.7.36. "Recovery" means the process in which people are able to live, work, learn, and participate fully in their communities.
- 1.7.37. "Regional Support Network (RSN)" means a county entity, an entity composed of multiple counties, or a private entity recognized by the Secretary, that is contracted to administer mental health services. RSN, if contextually required, can also mean a geographic area served by such an entity.
- 1.7.38. "Research-based" means a program or practice that has some research demonstrating effectiveness, but that does not yet meet the standard of evidence-based practices.

- 1.7.39. "Residential Services" means a complete range of residences and supports authorized by resource management services and which may involve a facility, a distinct part thereof, or services which support community living, for acutely mentally ill persons, chronically mentally ill adults, severely emotionally disturbed children, or seriously disturbed adults determined by the regional support network to be at risk of becoming acutely or chronically mentally ill. The services shall include at least evaluation and treatment services as defined in chapter 71.05 RCW, acute crisis, respite care, long-term adaptive and rehabilitative care, and supervised and supported living services, and shall also include any residential services developed to service mentally ill persons in Skilled Nursing Facilities boarding homes and adult family homes. Residential services for children in out-of-home placements related to their mental disorder shall not include the costs of food and shelter, except for children's long-term residential facilities existing prior to January 1, 1991.
- 1.7.40. "Resilience" means the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses, and to live productive lives.
- 1.7.41. "Risk Reserve" means funds designated into a risk reserve account by official action of the RSN's governing body. Risk reserve funds may only be used in the event costs of providing service exceed the revenue the RSN receives.
- 1.7.42. ~~Routine Services" means non-emergent and non-urgent services that are offered within 14 calendar days of the request for services to individuals authorized to receive services as defined in the access to care standards.~~ "means mental health services offered to occur within 14 calendar days of a decision to authorize ongoing mental health services. The time from request for mental health services to first routine appointment must not exceed 28 calendar days unless the Contractor documents a reason for the delay. Routine services are intended to stabilize, sustain, and facilitate consumer recovery within his or her living situation."
- 1.7.43. "Rural" means areas with a population density of at least 20 and less than 500 people per square mile.
- 1.7.44. "Secretary" means the Secretary of the Department of Social and Health Services.
- 1.7.45. "Service Area" means the geographic boundaries of the existing RSNs.

- 1.7.46. "Subcontract" means a separate contract between the RSN and an individual or entity ("Subcontractor") to perform any of the duties and obligations which the RSN is obligated to perform pursuant to this Agreement.
- 1.7.47. "Tribal Authority," for the purposes of this RFP and RCW 71.24.300 only, means: The federally recognized Indian Tribes and the major Indian organizations recognized by the secretary insofar as these organizational do not have a financial relationship with any regional support network that would present a conflict of interest.
- 1.7.48. "Urban" means areas that have a population density of at least 500 people square mile.
- 1.7.49. "Urgent Service" means a service to be provided to persons approaching a Mental Health crisis. If services are not received within 24 hours of the request, the person's situation is likely to deteriorate to the point that emergent care is necessary.
- 1.7.50. "WAC" means the Washington Administrative Code. All references to WAC chapters or sections shall include any successor to the referenced regulation.
- 1.7.51. "Waiver" means a document by which DSHS, MHD, requests sections of the Social Security Act (SSA) be waived, in order to operate a capitated managed care system to provide services to enrolled recipients. Section 1915(b) of the SSA, authorizes the Secretary to waive the requirements of sections 1902 of the SSA to the extent he or she finds proposed improvements or specified practices in the provision of services under Medicaid to be cost-effective, efficient, and consistent with the objectives of the Medicaid program.

## 2. RFP ADMINISTRATIVE INFORMATION AND REQUIREMENTS

### 2.1. Procurement Contact Information

All communications concerning this RFP only must be directed to the RFP Coordinator.

Contact the RFP Coordinator in writing by email, fax, or mail if you have any questions or concerns related to any portion of this RFP. Bidders should only rely on written Statements issued by the RFP Coordinator. Any other communication will be considered unofficial and non-binding on DSHS. Communication directed to parties other than the RFP Coordinator will have no legal bearing on this RFP and may result in disqualification of the Bidder.

Please contact the RFP Coordinator in writing with any questions or concerns.

### 2.2. Procurement Schedule

The Procurement Schedule outlines the tentative schedule for important dates and times. DSHS reserves the right to revise this schedule at any time and will post any amendment to the schedule on the DSHS Procurement website.

#### Procurement Schedule – all times are Pacific Time

Item	Action	Date
1.	Issue RFP – Available to download from DSHS Procurement website	March 1, 2006
2.	Bidders Letters of intent due	March 24, 2006
3	Pre- Proposal Conference (optional), this will be the last day questions will be accepted.	March 24 , 2006
4.	Written <del>proposal</del> <u>answers</u> to questions will be Issued	April 4- 20, 2006
5.	Proposal Submission Due by 3:00 PM	May 31, 2006
6.	<u>Pre-Final Score Briefing</u>	<u>June 16 and 19, 2006</u>
7.	<u>Written Clarification Due</u>	<u>June 21 – 22, 2006</u>
8.	Notify Bidders of Results	<del>June 30, 2006</del> <u>July 7, 2006</u>
9.	<del>RSN's</del> Request for Debriefing Due by 3:00 PM	<del>July 13-15</del> <u>July 12, 2006</u>
10.	Hold Debriefing Conferences (optional to <del>RSNs</del> )	<del>July 13-15, 2006</del> <u>July 13 or 14, 2006</u>
11.	<del>RSN's</del> <u>Bidders</u> Protest(s) Due	<del>July 20-21, 2006</del> <u>July 20 or 21, 2006</u>
12.	Signed Contracts Due	September 1, 2006
13.	Contract Execution	September 1, 2006
14.	Begin work	September 1, 2006

### 2.3. Letter of Intent

Bidders interested in submitting a proposal are first required to submit a Letter of Intent to the RFP Coordinator prior to the Pre-Proposal Conference. The Bidder must describe in the letter of intent how the Bidder meets the eligibility requirements described in section 1.3. This will serve as the process for Bidders to be recognized by the Secretary as potential RSNs.

In addition to the letter of intent, Bidders must notify the RFP Coordinator by e-mail or in writing identifying the service areas the Bidder's proposal will include. This notification is binding and the Bidder's proposal may only include the identified areas. This notification must be received by the RFP Coordinator on or before May 1, 2006. The state will also allow letters of intent that have been received by March 24, 2006 to be amended by May 1, 2006 to allow for bidders to submit consolidated proposals."

### 2.4. Pre-Proposal Conference

A conference to address questions about RFP requirements will be held at the time and location indicated below. Prospective Bidders are encouraged to attend; however, attendance is not mandatory. If changes to the RFP Documents are required as a result of the conference, an amendment will be issued and posted at the MHD Procurement website  
[http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml).

Date:	March 24, 2006
Time:	9:30 a.m. to 11:30 p.m.
Location:	Lookout Conference Room Office Building 2 Olympia, Washington

Directions are available on the MHD Procurement website.

Assistance for disabled, blind, or hearing-impaired persons who wish to attend is available with pre-arrangement with DSHS. Contact the RFP Coordinator identified on the face page of this document.

Specific questions concerning this RFP must be submitted to the RFP Coordinator in writing. DSHS will attempt to give preliminary answers at the Pre-proposal Conference to any questions received by 5:00 p.m. March 14, 2006. Additional questions will be entertained at the conference; however, answers will be deferred and provided formally in writing on or before April 20 ~~15~~, 2006.

The answer to any question that is given orally at the conference is tentative and unofficial and should not be relied upon by a Bidder. All questions and final DSHS answers, including any related amendments to the documents will be posted to the [http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml)

## 2.5. Questions and Answers

Bidders should fax, e-mail or mail written questions to the RFP Coordinator.

Submit Questions to: Andrew Kramer, RFP Coordinator  
Department of Social and Health Services  
Administrative Services Division, Central Contract Services

<b>Mailing Address:</b>	<b>Physical Address:</b>
P.O. Box 45811	4500 10 <sup>th</sup> Avenue SE
Olympia, Washington 98504-5811	Lacey, Washington 98503
Telephone: (360) 664-6073	
Fax: (360) 664-6184	
Email: <a href="mailto:rsnprocurement@dshs.wa.gov">rsnprocurement@dshs.wa.gov</a>	
Reference: <b>RFP #0634-202 E2SHB 1290 Procurement</b>	

**No questions related to the original RFP will be accepted after 5:00 p.m. on March 24, 2006.**

All questions and final DSHS answers, including any amendments to the documents will be posted at: [http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml) on or before April 20 45, 2006. Bidders should only rely on these written answers to questions.

**An additional question period will begin with the release of the RFP Amendment on April 20, 2006.**

Questions submitted during the additional question period will only be accepted between April 20, 2006 and May 3, 2006.

All questions and final DSHS answers, including any amendments to the documents will be posted at: [http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml) on or before May 17, 2006. Bidders should only rely on these written answers for submitted questions.

## 2.6. Acceptance of RFP Terms

A Proposal submitted in proposal to this RFP shall be considered a binding offer. Acknowledgement of this condition shall be indicated by submitting with the Proposal the BIDDER INFORMATION, CERTIFICATES AND ASSURANCES FORM attached

hereto as EXHIBIT A signed by a person legally authorized to bind the Bidder to contractual obligations.

## **2.7. Contract**

The Apparently Successful Bidders will be expected to sign contracts with DSHS that are modeled after the sample PIHP and State-funded contracts included as exhibits B and C. The contract may need to be modified depending on the legal structure of the Apparently Successful Bidder.

The period of performance of any contracts resulting from this RFP are tentatively scheduled to begin September 1, 2006. Amendments extending the period of performance, if any, shall be at the sole discretion of DSHS. DSHS reserves the right to extend the contracts.

Specific restrictions apply to contracting with current or former State employees pursuant to chapter 42.52 of the Revised Code of Washington. Bidders should familiarize themselves with the requirements prior to submitting a Proposal.

## **2.8. Written Representations**

Proposals must be based on the material contained in this RFP, any related amendment(s), and any questions and answers directed through the RFP Coordinator.

## **2.9. Exhibits**

**EXHIBIT A - BIDDER INFORMATION, CERTIFICATIONS AND ASSURANCES FORM**  
**EXHIBIT B – MODEL PIHP CONTRACT**  
**EXHIBIT C– MODEL STATE-FUNDED CONTRACT**  
**EXHIBIT D – CHECKLIST FOR RESPONSIVENESS**  
**EXHIBIT E - FISCAL AND POPULATION INFORMATION**  
**EXHIBIT F – SCORING TOOL AND WEIGHTING**

It is the Bidder's responsibility to download a complete copy of this RFP and all attached exhibits, as listed above. The procurement documents can be accessed at [http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml) Bidders may contact the RFP Coordinator to request hard copies. It is not grounds for protest if for any reason the Bidder does not have a complete and correct copy of the RFP document.

## **2.10. Administrative Requirements**

### **2.10.1. Letter of Submittal Requirements**

Bidders must provide a Letter of Submittal on official business stationery. The letter must be included as the first page of the proposal. The letter must be signed and dated by an individual with full authority to legally bind the entity submitting the proposal to this RFP. Signing the submittal letter indicates that the Bidder accepts the terms and conditions of this RFP and that the Bidder acknowledges and agrees to all of the rights of DSHS including the RFP rules and procedures, terms and conditions and all other rights and terms specified in this RFP, including any amendments.

The Letter of Submittal must include the following:

- 2.10.1.1. The name, address, principal place of business, telephone number, fax number, and e-mail address of the Bidder.
- 2.10.1.2. The name of the Bidders contact person for this RFP.
- 2.10.1.3. The location of the facility from which the Bidder operates.
- 2.10.1.4. A detailed list of all materials and enclosures included in the proposal.
- 2.10.1.5. A list of all RFP amendments downloaded by the Bidder from DSHS Procurements Website, if applicable, and listed in order by amendment number and date; if there are no RFP amendments; include a Statement to that effect.
- 2.10.1.6. Identification of the page numbers on the Bidder proposal that are marked "Proprietary or Confidential" information.

## **2.11. Costs to Propose**

DSHS is not liable for any costs incurred by the ~~RSN~~ Bidder in preparation of a proposal submitted in response to this RFP, in conduct of a presentation, or any other activities related to responding to this RFP.

## **2.12. Revisions to the RFP**

DSHS reserves the right, at any time before execution of contracts, to revise all or a portion of this RFP and/or to issue amendment(s) to the RFP including exhibits. If there is any conflict between amendments or between an amendment and the RFP, the last document issued shall be controlling. For this purpose, the specific questions and answers from DSHS shall be provided as an amendment to the RFP.

Amendments will be posted on the DSHS Procurements web site, if applicable. It is the responsibility of the Bidder to access the DSHS Procurement web site

[http://www1.dshs.wa.gov/Mentalhealth/RFP\\_Procurement.shtml](http://www1.dshs.wa.gov/Mentalhealth/RFP_Procurement.shtml) to access any and all notifications and amendments.

DSHS reserves the right to cancel or to reissue the RFP in whole or in part, prior to execution of contracts.

If the Bidder's copy of this RFP should be missing any exhibit or pages of the RFP or Exhibits it is not grounds for protest.

### **2.13. Proposal Rejection**

DSHS also reserves the right at its sole discretion to reject any and all proposals received without penalty and not to issue contracts as a result of this RFP.

### **2.14. Responsiveness**

A Checklist for Responsiveness is attached as Exhibit D to assist the Bidder in preparing the proposal.

An answer should be provided for every item. ~~indicated with an MR or MSR.~~ Failure to provide an adequate answer to any such subsection that requests information or solicits an answer may cause the proposal to be deemed non-responsive.

All proposals, as well as any reference material presented, must be written in English.

All proposals will be reviewed to determine compliance with the requirements and instructions specified in this RFP. The Bidder is specifically notified that failure to comply with any part of the RFP may result in rejection of the proposal.

DSHS reserves the right, at its sole discretion, to waive minor administrative irregularities.

### **2.15. Bidding On Multiple Service Areas**

A Bidder may bid on one or more of the available Service Areas only as currently configured— Grays Harbor, Northeast, Peninsula, Spokane and Thurston/Mason. The proposal should clearly indicate which Service Area(s) is included in the proposal.

If the Bidder qualified during the RFQ process and wishes to act as the RSN for both its current Service Area and one or more of the available Service Areas, the Bidder should submit a single proposal that responds to the requirements outlined in this RFP for both its current Service Area and the available Service Area(s) it is interested in.

If the Bidder did not qualify during the RFQ process or if the Bidder has not previously acted as an RSN in the state then the Bidder should submit a single proposal that responds to the requirements outlined in this RFP for one or more of the available Service Areas. DSHS reserves the right to contract with a bidder for any or all of the Service Areas identified in the proposal. A Bidder cannot act as the RSN for more than three of the Service Areas.

If the Bidder qualified during the RFQ process and bids on additional Service Areas as part of the RFP process but is not selected as an apparently successful bidder during the RFP then the Bidder will still be the RSN provider in the Service Area where it qualified during the RFQ.

## **2.16. Proposal Submission Format**

Submit seven copies of the proposal with one set marked as the Original. Include one electronic copy in any of the following formats Microsoft Word 2000 file format, ~~or~~ Microsoft Excel 2000 file format, PDF or JPG on a portable media or electronic readable media with a label identifying the Bidders name and RFP reference number as shown on the cover page of this RFP. Clearly mark the proposal to the attention of the RFP Coordinator and with the RFP reference number as shown on the cover page to this RFP.

Identify each copy of the proposal by including the RFP reference number as shown on the cover page of this RFP, the title of this RFP, and your name on the front cover. Boxes may not weigh more than 35 lbs each. In the event of any discrepancy between the copies, the hard copy marked Original will control.

The paper copy of the proposal must be on standard eight and one-half by eleven inch (8 ½" x 11") white paper. A font size not less than 12 point must be used. ~~Each page in the proposal must be numbered sequentially (including exhibits) and contain the name of the Bidder. Do not re-start numbering with each section.~~

Proposals may be submitted in one of the following two ways.

1. All pages numbered sequentially including attachments. Do not re-start numbering with each section; or
2. All pages numbered sequentially, excluding the attachments. Attachments must be included following each of the relevant questions. Every attachment must be labeled with the question number and tabbed. It is not necessary to tab each question within a subsection.

If the Bidder includes documents that have been created for another purpose these documents may be included in the original format.

Proposals must be submitted in locking three-ring binders with a table of contents and tabs identifying each subsection number and name. No binder may contain more than one section of the Proposal. A Bidder's response to a section may be contained in multiple binders. The sections are Section 3.1, Section 3.2, Section 3.3, Section 3.4, Section 3.5 and Section 3.8 ~~Section 3.6~~.

For each Requirements section and its corresponding Questions section:

- Step 1 – Restate the entire Requirements section.
- Step 2 – Restate each individual Question in the corresponding Questions section.
- Step 3 – Answer each individual Question. A reference to another section will not suffice, each answer must stand alone.
- Repeat 2 & 3 until all questions are answered.
- Step 4 – Insert a page break after each Requirement and Question sub-section.
- Step 5 – Insert attachments clearly labeled with the corresponding Question. If an attachment addresses more than one Requirement it must be duplicated in each question and named in accord with the Question(s) for that Requirement.
- Step 6 – Insert a page break after the attachments.

For the electronic copy: Each Requirements section must be in a separate folder, including all Requirements documents and all Questions documents. Attachments must be in the folder and be named in a manner that corresponds to the Question number or Questions numbers they pertain to. If attachments address more than one Requirement they must be duplicated in each folder and named in accord with the Question(s) for that Requirement.

## **2.17. Delivery of Proposals**

Bidders mailing proposals should allow normal mail delivery time to ensure timely receipt of the proposal. Bidders assume the risk for the method of delivery chosen. DSHS assumes no responsibility for delays caused by any delivery service. The proposal, whether mailed or hand delivered, must arrive at DSHS, at the address, date, and time indicated on the cover page to this RFP, unless other arrangements are approved by the RFP coordinator.

Proposals submitted by fax will not be accepted and will be considered non-responsive. DSHS reserves the right to disqualify any proposal and withdraw it from consideration if it is received after the proposal submission due date and time. All proposals and any accompanying documentation become the property of DSHS and will not be returned.

## **2.18. Errors and Omissions in Proposals**

DSHS will not be liable for any errors or omissions in the Bidders proposal. Bidders will not be allowed to alter or supplement their proposal documents after the

proposal due date unless the alterations are the result of a request by DSHS as noted below.

DSHS reserves the right at its sole discretion to make corrections or amendments to the proposal due to errors identified by DSHS or the Bidder. This type of amendment will only be allowed for such errors as typing, transposition, omission, or any other obvious error. Any changes will be date and time stamped and attached to Proposals. All changes must be coordinated in writing with, authorized by, and made by the RFP Coordinator. Bidders are liable for all errors or omissions contained in their proposals and do not have a right to correction or amendment.

#### **2.19. Withdrawal of Proposals**

Bidders may withdraw a proposal that has been submitted at any time up to the proposal due date and time. To accomplish this, a written request signed by an authorized representative of the Bidders must be submitted to the RFP Coordinator. After withdrawing a previously submitted proposal, the Bidder may submit another proposal at any time up to the closing date and time.

#### **2.20. Proprietary Information/Public Disclosure**

Materials submitted in proposal to this RFP shall become the property of DSHS.

All proposals received shall remain confidential until the contract, if any, resulting from this RFP, is signed by DSHS and the apparent successful Contractor: thereafter, the proposals shall be deemed public records as defined in RCW 42.17.250 to .340, "Public Records."

Any information in the proposal that the Bidder desires to claim as proprietary and exempt from disclosure under the provisions of RCW 42.17.250 to .340 must be clearly designated. Each page claimed to be exempt from disclosure must be clearly identified by the words "Proprietary Data" printed on the lower right hand corner of the page. Each page marked as such must be included in a statement that identifies the particular exception from disclosure upon which the Bidder is making the claim.

DSHS will consider a Bidder's request for exemption from disclosure; however, DSHS will make a decision predicated upon applicable laws. The Bidder must be reasonable in designating information as confidential. If any information is marked as proprietary in the proposal, such information will not be made available until the affected Bidder has been given an opportunity to seek a court injunction against the requested disclosure as provided by law.

Marking the entire proposal exempt from disclosure will not be honored and will, in fact, be grounds for disqualification from the evaluation process.

DSHS' sole responsibility shall be limited to maintaining the above data in a secure area and to notify ~~RSN~~ the Bidder of any request(s) for disclosure within a period of five (5) years from date of award. Failure to so label such materials or failure to provide a timely proposal after notice of request for public disclosure has been given shall be deemed a waiver by the Bidder of any claim that such materials are, in fact, so exempt. Confidentiality is available only to the limited extent allowed in State law. DSHS may choose to disclose despite information being marked as confidential.

A charge will be made for copying and shipping, as outlined in RCW 42.17.300. No fee shall be charged for inspection of contract files, but 24-hour notice to the RFP Coordinator is required. All requests for information should be directed to the RFP Coordinator.

## **2.21. Initial Proposal Review**

All proposals will be reviewed for completeness and compliance with the administrative requirements and instructions specified in this RFP. Responsive proposals will advance to the evaluation teams. Please use the checklist provided. Only proposals meeting the requirements will advance for further evaluation. DSHS reserves the option to delete any mandatory item.

## **2.22. Evaluation, Scoring and Contract Award**

### **2.22.1. Evaluation of Responses**

Responses that pass the Initial Proposal Review will be evaluated and scored based upon ~~RSN's Bidders~~ answers to the specific questions in the RFP. The evaluators will consider how well the Bidders answers to the questions meet the requirements. The evaluation will be based only upon the response and not upon the evaluator's external experience with, or perception of, the Bidder or upon Bidder presentations made prior to the release of this document. All proposals will be evaluated strictly in accordance with the requirements set forth in this RFP and any amendments thereto.

There will be an executive review for comportment with the RFP process and criteria.

### **~~2.22.2. Mandatory Requirements~~**

~~A Mandatory Requirement (MR) must be met by the Bidder. MRs are scored as pass or fail. Questions that are MRs are identified in Section 3, Proposal Contents.~~

~~Failure to meet a mandatory requirement shall be established by any of the following conditions:~~

- ~~2.22.2.1. The Bidder states that a mandatory requirement cannot be met.~~
- ~~2.22.2.2. The Bidder fails to include information requested by or necessary to substantiate that a given mandatory requirement has been met. Supplemental material may be referenced, but the answer must be complete in itself. An answer of "will comply" is not sufficient.~~
- ~~2.22.2.3. The Bidder does not indicate present capability to meet a MR, when required. Representations that future developments will satisfy a current requirement are not sufficient.~~
- ~~2.22.2.4. The Bidder presents the information requested by this RFP in a manner inconsistent with the instructions stated by any portion of this RFP.~~
- ~~2.22.2.5. DSHS determines through references, site visits, or other investigation that the Bidder is unable to comply with one or more of the mandatory requirements.~~

~~DSHS reserves the right to waive any mandatory requirement for all Bidders during the selection of Apparently Successful Bidders.~~

### **2.22.3. Mandatory Scored Requirements**

A mandatory scored requirement (MSR) is an essential need that must be met by the responder. Bidders are required to respond to all MSRs. ~~Questions that are MSRs are identified in Section 3, Proposal Contents.~~

~~Each MSR question within subsection within a section will be given a consensus score by the assigned evaluation team. Each evaluation team will score independently of other teams. Upon completion of consensus scoring, the scores will be given to the RFP Coordinator.~~

~~A score of 0 may be grounds for disqualification and shall be established by using the same criteria used to establish that an MR is not met.~~

Each question within a MSR subsection will be given a rating of 0-10 by each evaluator using the scoring tool attached as Exhibit F. Weighting will be applied to the scores by the RFP Coordinator based on the table provided in Exhibit F.

Points available for each section are based on the following table.

System Improvement Initiatives	Fiscal and Administration	Information Systems	Program Requirements	Quality Requirements
20	20	5	20	35

#### 2.22.4. **Possible Minimum Acceptable Score**

A Bidder that does not receive at least 70% 60% of the total available MSR points for its proposal ~~may~~ will be disqualified.

See scoring tool, Exhibit F.

#### 2.22.5. **Corrective Action**

Prior to executing contracts resulting from the RFP ~~RFQ~~, DSHS may, at its sole discretion, require an Apparently Successful Bidder to submit a corrective action plan (CAP) to fully address compliance with any requirement where DSHS, in its sole judgment, considers the Bidder's response less than fully compliant. The CAP is subject to review and approval by DSHS.

#### 2.22.6. **Reference Checks**

~~By submitting a proposal the Bidder expressly gives DSHS permission to obtain information concerning the proposal pertinent to this RFP from any and all sources, and to consider such information in evaluating the responses and selecting the Apparently Successful Bidder.~~

#### 2.22.7. **Evaluation Teams**

~~The department will determine whether proposals are responsive to the MRs. The evaluation of MSRs shall be accomplished by several evaluation teams, to be designated by DSHS. Evaluation teams will score the Mandatory Scored Requirements (MSR). and make recommendations to the Department on select MRs.~~ The RFP Coordinator, RFP Manager and staff involved in RFP development will not serve as evaluators for MSRs, but may develop information for presentation to the teams. Responses will be evaluated strictly in accordance with the requirements set forth in this RFP and any amendments that are issued.

#### 2.22.8. **Contract Award**

The evaluation process is designed to award the contracts to the Bidders whose proposals best meet the requirements of this RFP. The final selection will made at the completion of the process described below.

~~The RFP Coordinator will compile the scores provided by the evaluation teams.~~

##### 2.22.8.1. **Preliminary Scores**

The RFP Coordinator will average the individual evaluator scores for each question in sections 3.1 through 3.5 and apply the weighting to each subsection as described in Exhibit F. The weighted scores will be totaled resulting in a base score.

After the RFP coordinator calculates the base score, bonus points will be awarded based on the Bidder's response to Section 3.8. There are a total of five bonus points available. The Bidder's response to Section 3.8 is scored by each evaluator on a 1 to 10 scale. The RFP coordinator will average the individual evaluators' scores for section 3.8 and divide by two to calculate the amount of bonus points to add to the bidder's base score.

After the bonus points, if any, are added to the base score the score will be rounded to the nearest whole number resulting in the preliminary score. If the preliminary score is not a whole number it will be rounded up to the nearest whole number if the numeral in the tenths position is greater than or equal to 5. If the preliminary score is not a whole number it will be rounded down to the nearest whole number if the numeral in the tenths position is less than 5. Following this process a Pre-Final Score Briefing will occur.

#### **2.22.8.2. Pre-Final Score Briefing**

Prior to the final evaluation and final scoring of the proposals, each bidder will be provided with an opportunity for a detailed briefing regarding any deficiencies in its proposal and provided an opportunity to clarify information submitted in its original proposal.

2.22.8.2.1. The initial briefing conference may be conducted in person or by telephone and will be scheduled for a maximum of two hours. Discussion at the initial briefing conference will be limited to the following topics:

- Evaluation and scoring of the proposal.
- Critique of the proposal based on evaluators' comments.

2.22.8.2.2. Following the initial briefing conference, the bidder will have an opportunity to clarify information submitted in its original proposal. Clarifications must be in writing and include the following:

- The name of the Bidder, mailing address, and telephone number, and the name of a contact person for the clarification
- The RFP number and title

2.22.8.2.3. The clarification must include a detailed identification of each question which the bidder is clarifying followed by identification of the specific language in its original proposal that speaks to the identified deficiency.

- 2.22.8.2.4. DSHS will not consider information which it determines at its sole discretion is new information and not a clarification of information included in the original proposal.
- 2.22.8.2.5. A Bidder's clarification must be submitted to the RFP Coordinator both in electronic format as an attachment to an email and also in written hard copy format with appropriate signature.
- 2.22.8.2.6. DSHS must receive the electronic email clarification within three (3) business days after the pre-final evaluation briefing conference.

In addition, the Bidder must mail or hand deliver a written and signed hard copy of the clarification. If mailed, the clarification must be postmarked within three (3) business days after the pre-final evaluation briefing conference. If hand delivered, the protest must be received within three (3) business days of the pre-final evaluation briefing conference.

In the event of a difference between the clarification submitted electronically and the hard copy, the electronic copy will prevail.

### **2.22.8.3. Clarification Review Process**

The RFP Coordinator will forward the Bidders clarification to the DSHS-designated clarification review team with copies of the following:

- The RFP and any amendments
- The Bidder's proposal
- The evaluators' scoring sheets and comments

- 2.22.8.3.1. The clarification review team will review the clarification based on the contents of the clarification and the above materials provided by the RFP Coordinator.
- 2.22.8.3.2. DSHS will send a written decision within five business days after the clarification is received, unless more time is required to review the clarification and make a determination. The Bidder will be notified by the RFP Coordinator if additional time is necessary.

2.22.8.3.3. The clarification review team's review will result in one of the following findings:

- The clarification lacks merit and the RFP scores are upheld.
- The clarification has merit and scores are adjusted.

## **2.22.9. Award of Service Areas**

2.22.9.1. Each Bidder must clearly identify the Service Areas for which it is bidding. No Bidder may serve more than three current Regional Support Network Service Areas. If a Bidder proposes to serve more than three current Regional Support Network Service Areas, DSHS reserves the right to choose the three Service Areas that best meet the needs of DSHS using the same criteria defined herein under Section 2.22.9.3.

2.22.9.2. The procedure for the award of Service Areas will be as follows:  
~~and in accordance with 2.26.9.1.~~

2.22.9.2.1. The highest scoring Bidder will be awarded up to three of the Services Areas requested in its proposal.

2.22.9.2.2. The next highest scoring Bidder will be awarded all Service Areas proposed that do not overlap with a higher scoring Bidder.

2.22.9.2.3. Award of Service Areas will proceed as stated above until all Service Areas are awarded.

2.22.9.3. In the event of a tie DSHS will consider the following in determining the order in which to award Service Areas:

2.22.9.3.1. Which proposal provides for the best continuity and coordination of care for consumers.

2.22.9.3.2. Which proposal best meets DSHS' Service Area needs.

## **2.23. Notification of Bidders**

DSHS will notify Bidders of the results of the RFP on or about the date and time specified in the Procurement Schedule by written notice via mail, e-mail, and/or fax.

## **2.24. Execution of the Contracts**

Apparently Successful Bidders will be expected to sign contracts with DSHS that are modeled on those attached as Exhibits B and C. The contract may need to be modified depending on the legal structure of the Apparently Successful Bidder. Refusal to sign the contract or any subsequent amendment within thirty (30) calendar days of delivery of the final contracts may result in cancellation of the award.

## **2.25. Debriefing and Protest Procedures**

### **2.25.1. Debriefing**

2.25.1.1. After clarification and final scoring, unsuccessful Bidders will be given the opportunity for a debriefing conference. The RFP Coordinator must receive the request for a debriefing conference via mail, e-mail, or fax within two business days of the Notification of Unsuccessful Bidders. The debriefing must be held within three business days of the request.

2.25.1.2. Debriefing conferences may be conducted in person or by telephone and will be scheduled for a maximum of one hour. Discussion at the debriefing conference will be limited to the following topics:

- Evaluation and final scoring of the proposal.
- Critique of the proposal based on evaluators' comments.
- Review of the Bidder's final score in comparison with other Bidder's final scores without identifying the other Bidders.

### **2.25.2. Protest Procedure**

In order to submit a protest under this RFP, a Bidder must have submitted a proposal for this RFP, and have requested and participated in a debriefing conference. It is the sole administrative remedy available within DSHS.

#### **2.25.2.1. Grounds for Protest**

A protest may be made based on these grounds only:

2.25.2.1.1. Arithmetic errors were made by DSHS in computing the score;

2.25.2.1.2. DSHS materially failed to follow the procedures established in this RFP document, or to follow applicable State or federal laws or regulations; or

2.25.2.1.3. Bias, discrimination, or conflict of interest on the part of an evaluator.

#### 2.25.2.2. Protest Form and Content

A protest must state all of the facts and arguments upon which the protest is based. It must be in writing and signed by a person authorized to bind the Bidder to a contractual relationship. The protest must include:

- a. The name of the protesting Bidder, mailing address, and telephone number, and the name of a contact person for the protest;
- b. The RFP number and title.
- c. A detailed and complete Statement of the specific action(s) by DSHS under protest.
- d. A description of the relief or corrective action requested.
- e. Any documentation offered to support the protest may be attached.

#### 2.25.3. Submitting a Protest

A Bidder's protest must be submitted to the RFP Coordinator both in electronic format as an attachment to an email and also in written hard copy format with appropriate signature.

DSHS must receive the electronic email protest within five (5) business days after the debriefing conference. The Bidder must email a protest to the RFP Coordinator.

The Bidder must also mail or hand deliver a written and signed hard copy of the protest. If mailed, the protest must be postmarked within five (5) business days after the debriefing conference. If hand delivered, the protest must be received within five (5) business days of the debriefing conference.

In the event of a difference between the protest submitted electronically and the hard copy, the electronic copy will prevail. ***Protests may not be submitted by fax.***

##### 2.25.3.1. Protest Process

The RFP Coordinator will forward the protest to the DSHS-designated Protest Coordinator with copies of the following:

- 2.25.3.1.1. The RFP and any amendments
- 2.25.3.1.2. The Bidder's proposal
- 2.25.3.1.3. The evaluators' scoring sheets and comments

The Protest Coordinator will conduct an objective review of the protest, based on the contents of the written protest and the above materials provided by the RFP Coordinator.

#### 2.25.3.2. Final Determination

DSHS will send a written decision within five business days after the protest is received, unless more time is required to review the protest and make a determination. The protesting Bidder will be notified by the RFP Coordinator if additional time is necessary.

The Protest Coordinator's review will result in one of the following findings:

- 2.25.3.2.1. The protest lacks merit and the RFP results are upheld.
- 2.25.3.2.2. Any errors in the RFP process or in DSHS' conduct did not influence the outcome of the RFP, and the RFP results are upheld.
- 2.25.3.2.3. The protest has merit.
- 2.25.3.2.4. If the protest has merit, the RFP coordinator may direct DSHS to:
  - Correct any errors and re-evaluate all proposals affected by the determination of the protest.
  - Reissue the RFP document.
  - Take such other action as may be appropriate.
- 2.25.3.2.5. If DSHS determines that the protest is without merit, DSHS will complete the procurement by contracting with Apparently Successful Bidders.

#### 2.25.4. Legislative Testimony

The Bidder may be expected to testify before the Washington State Legislature at the conclusion of the RFP process. Submission of a proposal serves as acknowledgement and agreement to the above condition.

### **3. PROPOSAL CONTENTS**

This section of the RFP outlines the proposal contents: the requirements, qualifications, and questions that comprise the proposal narrative. Any requirement and question not identified as being for either the Title XIX or State-funded Program is a requirement and question for both programs. A proposal must have six sections:

- 3.1 System Improvement Initiatives and Tribal Authority Relationships
- 3.2 Administrative and Financial Requirements
- 3.3 Information System Requirements
- 3.4 Program Requirements
- 3.5 Quality Requirements
- ~~3.6 Transition Plan~~
- ~~3.7 Questions for Transition Plan~~
- 3.8 Scoring Factor for Additional Financial Resources

#### **3.1. Tribal Authority Relationships and System Improvement Initiatives**

During 2005, new legislation was signed into law that provides a vision and direction for the Washington State mental health system. These new requirements are described below.

##### **3.1.1. Tribal Relationship Requirements**

- 3.1.1.1. A RSN must inform Tribal Authorities within the Service Area of their right to be represented as a party to the Regional Support Network and of opportunities to collaborate with the RSN to provide culturally competent services to Tribal members. All RSN's will be required to comply with RCW 71.24.300.
- 3.1.1.2. A RSN shall develop a separate RSN/Tribal Plan in collaboration with each Tribal Authority within the RSN's Service Area that includes the following:
  - 3.1.1.2.1. Coordination and collaboration with the Tribe regarding Title XIX and State-funded mental health services for Tribal members.
  - 3.1.1.2.2. Coordination and collaboration with RSNs and Tribes when tribal boundaries cross RSN boundaries.
  - 3.1.1.2.3. Identification of a contact person(s) and/or process within the RSN to assist in integration of agreements with the Tribes.
  - 3.1.1.2.4. The reduction of duplicative screening and evaluation processes and ongoing coordination of care between the

Tribes and RSN for Tribal members receiving their primary outpatient mental health care from a Tribal provider, and who may need or be receiving Title XIX or State-funded mental health services through an RSN authorized provider.

3.1.1.3. The RSN must develop working protocols and procedures with Tribal facilities and/or Tribal providers, upon request by a Tribe, to address the following:

- 3.1.1.3.1. Provision of Title XIX services to Tribal members who are Title XIX enrollees and who choose to receive mental health services through an RSN provider.
- 3.1.1.3.2. Provision of non-Medicaid services, including crisis services and involuntary treatment services as defined in RCW 71.05 and RCW 71.34 to Tribal members.
- 3.1.1.3.3. Provision of Mental Health Specialist consultations as required in WAC 388-864-0425.

**3.1.2. Tribal Relationship Questions (MSR MR)**

- 3.1.2.1. If there is not currently a Tribal Authority, as defined in this RFP, within the boundaries of the Service Area, document this and answer only ~~sections 3.1.2.3 and~~ 3.1.2.4 and 3.1.2.5 below.
- 3.1.2.2. Describe how the Bidder will inform a Tribal Authority within each Service Area of its rights to be represented as a party to the RSN and of opportunities to collaborate to provide culturally competent services to Tribal members.
- 3.1.2.3. Provide any collaboration plans that are currently in place or a work plan ~~or~~ that will result in a collaboration plan with Tribal Authorities in the Service Area by September 1, 2006. Provide documentation if the Tribal authority declines to participate.
- 3.1.2.4. Describe current and future procedures for coordinating care with Tribal Facilities and/or providers.
- 3.1.2.5. Describe how the Bidder will measure and report outcomes for the requirements.

**3.1.3. Consumer Participation Requirements**

The contracted RSN must do the following:

- 3.1.3.1. Provide information to consumers, families, and service providers on mental health and models of client-driven services.
- 3.1.3.2. Encourage and facilitate the development of consumer-operated services.
- 3.1.3.3. Involve consumers and family members as participants in governance, administration, and the evaluation of service delivery, and evaluation.
- 3.1.3.4. Develop and implement policies and procedures that enhance participation of consumers and family members in the development of individual service plans and monitor provider subcontractors for compliance with this requirement.
- 3.1.3.5. Include consumers and their family members in the planning for service coordination among State and local agencies, including those that provide services to children and elders, criminal justice agencies, K -12 schools, and among State psychiatric hospitals, county authorities, community mental health services, and other support services.
- 3.1.3.6. Include consumers and families as members of the Mental Health Advisory Board as required by WAC 388-865-0222.

#### 3.1.4. **Consumer Participation Questions (MSR)**

Describe past experiences and/or approach to promoting consumer involvement and provide a detailed plan that addresses the following requirements:

- 3.1.4.1. Provision of information to consumers, families, and service providers on developing models of client driven services.
- 3.1.4.2. Plans to implement consumer-operated services or consumer operated businesses.
- 3.1.4.3. Involvement of consumers and family members as participants in governance, administration, and evaluation of service delivery.
- 3.1.4.4. Development and implementation of policies and procedures that enhance participation of consumers and family members in individual service planning, and monitoring of compliance with this requirement.
- 3.1.4.5. Inclusion of consumers and their families in the planning for coordination of services among State and local agencies, including

those that provide services to children and elders, criminal justice agencies, K – 12 schools, and among State psychiatric hospitals, county authorities, community mental health services, and other support services.

3.1.4.6. Inclusion of consumers and families on decision making committees that provide oversight and problem resolution the service delivery system.

3.1.4.7. Inclusion of consumers and families as members of the Mental Health Advisory Board as required by WAC 388-865-0222.

### **3.1.5. Promoting Recovery and Resilience Requirements**

The contracted RSN must do the following:

3.1.5.1. Provide services that promote recovery and resiliency.

3.1.5.2. Provide ongoing training and information to staff and subcontracted providers on strategies and services that promote wellness, recovery, and resilience. The training and information shall emphasize the following principles:

3.1.5.2.1. Mental health will be understood as an essential element of overall health.

3.1.5.2.2. Mental illness shall be understood as a condition from which people can and do recover.

3.1.5.2.3. Recovery from mental illness involves regaining a sense of purpose and control over one's life that overcomes, to the extent possible, limitations imposed by the illness.

3.1.5.2.4. Resilience and Recovery-oriented approaches that provide opportunities for consumers to manage their mental illness; rebound from adversity, trauma, tragedy, threats, or other stresses; maintain their independence; and live productive lives.

3.1.5.3. Integrate wellness/recovery models into culturally competent individualized service plans. The individualized service plan shall include information on quality of life outcomes, as desired by the consumer. Quality of life outcomes must at a minimum address education, employment and self-directed care.

### 3.1.6. Promoting Recovery And Resilience Questions (MSR)

Describe any currently in place plans or past experiences and approach to promoting recovery and resilience that addresses the following requirements:

- 3.1.6.1. How providers will be assisted with understanding and implementing tools and supports that promote recovery and resilience.
- 3.1.6.2. How information and training to staff and providers on recovery and resilience will be provided.
- 3.1.6.3. How consumers and families will be involved in the development of wellness and recovery based services.
- 3.1.6.4. How consumer cultural needs and individual diversity will be identified and addressed.
- 3.1.6.5. How individual service plans will be developed to reflect recovery and resiliency principles including cultural competence.
- 3.1.6.6. How quality of life outcomes for consumers will be tracked.

### 3.1.7. Evidence-Based, Research-Based, Consensus-Based, and Promising or Emerging Best Practices Requirements

The Mental Health Division is committed to operating a community mental health system that is based on Evidenced based practices by January 2009.

The following evidence-based and promising practices have been identified as a priority for implementation.

#### Evidence-Based Practices

<b>Adults</b>	Assertive Community Treatment	Family Psychological Education	Supported Employment	Dialectic Behavior Therapy
<b>Children</b>	Multi-Systemic Therapy	Functional Family Therapy	Multi-Dimensional Treatment Foster Care	Trauma Focused Cognitive Behavioral Therapy
<b>Co-Occurring Disorders</b>	Co-Occurring Mental Health/Chemical Dependency Treatment			

#### Promising Practices

<b>Adults</b>	Illness Self Management	
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<b>Children</b>	Wrap Around	Dialectic Behavior Therapy
<b>Older Adults</b>	Gatekeeper for Older Adults	Medication Algorithms

- 3.1.7.1. The RSN must have written policies and procedures and an implementation plan with timelines addressing how any evidence-based, research-based, consensus-based, and promising or emerging best practices are selected and adopted.

There is no specific number of practices that must be adopted. The RSN is required to increase access to evidence-based, research-based, consensus-based, and promising or emerging best practices.

The RSN may select from the practices identified by the DSHS or from others that best meet the needs of the population served. The policies and procedures must include:

- 3.1.7.1.1. Detailed methodology for adoption of any practices.
- 3.1.7.1.2. A detailed review of the DSHS Evidence-Based Practices and Promising Practices to determine if any are appropriate for adoption in the Service Area.
- 3.1.7.1.3. A detailed review of the cultural competence and appropriateness of any research-based, consensus-based, and promising practices for ethnic, racial, and cultural minorities living within the RSN's geographic boundaries. This must include a process for deciding which practices will be considered for adoption to address ethnic, cultural, and linguistic needs of the population to be served.
- 3.1.7.1.4. Incorporation of consumer, family member, and advocate input into the prioritization and implementation of practices.
- 3.1.7.1.5. Provider involvement in the decision making process for choosing and implementing practices.
- 3.1.7.1.6. Tools and methods to promote and monitor that ensure provider compliance with the chosen practices, including monitoring for fidelity to the practice models.

### **3.1.8. Evidence-Based, Research-Based, Consensus-Based, and Promising or Emerging Best Practices Questions (MSR)**

- 3.1.8.1. Describe the Bidders experience with adoption and implementation of any evidence-based, research-based, consensus-based, and

promising or emerging best practices. List any practices that have been adopted or are under consideration for adoption by the Bidder. Include a timeline for adoption and implementation of any practices that are under consideration.

- 3.1.8.2. Provide a written description, including any existing policies and procedures that address how the Bidder will utilize evidence-based, research-based, consensus-based, and promising or emerging best practices in accordance with the requirements above.
- 3.1.8.3. Provide a plan that describes in detail how consumers will be educated about and provided access to evidence-based, research-based, consensus-based, and promising or emerging Best practices.

### **3.1.9. Allied System Coordination Requirements**

- 3.1.9.1. The RSN shall develop a written allied system coordination plan for each of the following in each Service Area that is being proposed:

- 3.1.9.1.1. Department of Social and Health Services

- Aging and Disability Services Administration (ADSA)
      - Division of Developmental Disabilities
      - Home and Community Services Division
    - Juvenile Rehabilitation Administration (JRA)
    - Children's Administration (CA)

- 3.1.9.1.2. Local Chemical Dependency and Substance Abuse service providers

- 3.1.9.1.3. Community Health Clinics, Federally Qualified Health Centers (FQHCs), and Healthy Options Plans (Medicaid Managed Care Health Plan and the State Children's Health Insurance Program).

- 3.1.9.1.4. Local Criminal Justice (courts, jails, law enforcement, public defender, Department of Corrections)

- 3.1.9.1.5. K-12 Education System as needed

- 3.1.9.2. Each allied system coordination plan must contain the following:

- 3.1.9.2.1. Clarification of roles and responsibilities of allied systems in serving persons mutually served.

- 3.1.9.2.2. Processes for sharing of information related to eligibility, access, and authorization.
- 3.1.9.2.3. Identification of needed local resources, including initiatives to address those needs.
- 3.1.9.2.4. Process for facilitation of community reintegration from out-of-home placements (e.g., State hospitals, Children's Long-term Inpatient Program, Juvenile Rehabilitation Administration facilities, foster care, skilled nursing facilities, acute inpatient settings) for consumers of all ages.
- 3.1.9.2.5. A process to address disputes related to service or payment responsibility.
- 3.1.9.2.6. A process to evaluate cross-system coordination and integration of services.
- 3.1.9.3. The coordination plans shall be developed by September 1, 2006.
- 3.1.9.4. For the Division of Developmental Disabilities (DDD), the plan must also specifically address:
  - 3.1.9.4.1. Admission and discharge of persons to the State's Psychiatric Hospitals, including oversight of discharge planning for individuals served by the State psychiatric hospitals who are also enrolled with DDD.
  - 3.1.9.4.2. Crisis management and the use of joint resources to address crises (e.g., assessing if the crisis is related to loss of housing, psychiatric issues, behavior management and identification of services and supports to mitigate the crisis).
- 3.1.9.5. For Chemical Dependency and Substance Abuse services the plan must also specifically address:
  - 3.1.9.5.1. Protocols for assessing the presence of co-occurring disorders.
  - 3.1.9.5.2. Provision of integrated treatment for persons with co-occurring disorders.
  - 3.1.9.5.3. Use of evidence-based, research-based, and consensus-based practices for persons with co-occurring disorders.

3.1.9.6. For Children's Administration the plan must also specifically address:

3.1.9.6.1. Availability of an intake to all Medicaid enrolled children, including children in foster care.

3.1.9.6.2. Availability of culturally-competent, evidence-based, consensus-based, and promising practices for children, especially for children with multiple agency involvement (e.g., dependency court, protective services, foster care, mental health, juvenile rehabilitation).

3.1.9.7. The plan for community health clinics, federally qualified health centers (FQHCs), and Healthy Options plans must also specifically address:

3.1.9.7.1. Protocols for accessing health and mental health services for persons mutually served.

3.1.9.7.2. Coordination of care with primary care physicians or other health professionals.

3.1.9.8. The plan for criminal justice organizations must also specifically address:

3.1.9.8.1. For Department of Corrections address coordination with any Dangerous Mentally Ill Offender program in the RSN Service Area for which the RSN is not the DMIO contractor with MHD. A description of the DMIO program can be found on the RSN Procurement web site.

### **3.1.10. Allied System Coordination Question (MSR)**

3.1.10.1. Provide a detailed plan that may include policies and procedures or any existing coordination plans to have each of these plans in place by September 1, 2006. This must include a timeline and the specific plan requirements described above for each program.

## **3.2. Administrative and Financial Requirements**

### **3.2.1. Timeliness of Provider Payment Requirements**

Payments to providers by the RSN shall be made on a timely basis, consistent with claims payment procedures described in 1902(a)(37)(A) of the Social Security Act and 42 CFR 447.45. The RSN shall ensure that 90 percent of all clean claims for covered services, for which no further written information or

substantiation is required in order to make payment, are paid within 30 days of the date of approval; and that 99 percent of such claims are paid within ~~480~~ 90 days of the date of receipt.

### **3.2.2. Timeliness of Provider Payment Questions (~~MR~~ MSR)**

- 3.2.2.1. For claims that result in actual cash payments to providers, describe how claims will be paid in a timely manner and the methods that will be implemented to monitor claim timeliness and payment accuracy.
- 3.2.2.2. Describe how the Bidder will measure and report outcomes for these requirements.

### **3.2.3. Provider Claim Disputes Requirements**

The RSN shall develop and implement a provider claim disputes process in accordance with all applicable federal and State laws. When the RSN denies a claim, the RSN shall notify the provider in writing of the claim denial and inform the provider of the right to appeal and the specific procedure to file an appeal.

### **3.2.4. Provider Claim Disputes Question (~~MR~~ MSR)**

Describe the provider claim dispute process that will be in place. Describe plans to provide prompt resolution to claims disputes and a process for verifying all disputes have been resolved.

### **3.2.5. Payments From Medicaid Enrollees Requirements**

The RSN must ensure that Medicaid enrollees are not charged for Medicaid covered services including out-of-network services, and are not held liable for any of the following:

- 3.2.5.1. Services provided by an insolvent community psychiatric hospitals with which the RSN has directly contracted.
- 3.2.5.2. Covered Mental Health services, including those purchased on behalf of the enrollee.
- 3.2.5.3. Covered Mental Health services provided to the enrollee for which the State does not pay the RSN or the RSN does not pay the MHCP or CMHA that furnishes the services under a contract, referral, or other arrangement, to the extent that those payments are in excess of the amount the enrollee would owe if the RSN provided the services directly.

### **3.2.6. Payments From Medicaid Enrollees Questions (MR MSR)**

- 3.2.6.1. Describe any monitoring, review process or other procedures that will be used to safeguard against charges being billed to Medicaid enrollees as described in the requirements above. This must include processes that are or will be used to monitor the solvency of contracted providers.

### **3.2.7. Report Submission Requirements**

- 3.2.7.1. The RSN is responsible for submitting complete financial reports accurately and in a timely manner.

### **3.2.8. Report Submission Questions (MR MSR)**

- 3.2.8.1. Describe the process and procedures in place to ensure reports will be complete, accurate and submitted in a timely manner to MHD.
- 3.2.8.2. Provide a description of the Bidder's accounting and information system and the Bidder's ability to implement changes in reporting requirements or respond to ad-hoc financial data requests.
- 3.2.8.3. Describe how the Bidder will measure and report outcomes for these requirements.

### **3.2.9. Fraud and Abuse Requirements**

- 3.2.9.1. In the context of Fraud and Abuse Requirements, abuse means a provider practice that is inconsistent with sound fiscal, business, or medical practices and result in an unnecessary cost to the Medicaid program, or in payment for services that are not medically necessary or that fail to meet professionally recognized standards for health care (Medicaid Managed Care Fraud and Abuse Guidelines).
- 3.2.9.2. In the context of Fraud and Abuse Requirements, fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to the person or some other person. It includes any act that constitutes fraud under applicable federal or State law (Medicaid Managed Care Fraud and Abuse Guidelines).
- 3.2.9.3. The RSN must have administrative procedures and internal controls including a mandatory compliance plan designed to guard against fraud and abuse which must at a minimum contain the following:

- 3.2.9.3.1. Verification that services reimbursed by Medicaid were actually furnished to enrollees.
- 3.2.9.3.2. Written policies, procedures, and standards of conduct that articulate the RSN's commitment to comply with all applicable federal and State standards.
- 3.2.9.3.3. Designation of a compliance officer and a compliance committee accountable to senior management.
- 3.2.9.3.4. Training and education for the compliance officer and employees.
- 3.2.9.3.5. Communication between the compliance officer and employees.
- 3.2.9.3.6. Enforcement of standards through well-publicized disciplinary guidelines.
- 3.2.9.3.7. Internal monitoring and auditing.
- 3.2.9.3.8. Prompt response to detected offenses, and for development of corrective action initiatives relating to the contracts.

#### **3.2.10. Fraud and Abuse Question (MR MSR)**

Submit a documentation of processes used to guard against fraud and abuse. This must include a Compliance Plan covering the requirements described above. In addition to the Compliance plan policies and procedures or other descriptions of internal controls must be included.

#### **3.2.11. Sentinel Events and Negative Media Coverage Requirements**

- 3.2.11.1. The RSN must notify MHD of any incident when there is sentinel event and/or negative media coverage expected. Examples of incidents to report include, but are not limited to: homicide, attempted homicide, completed suicide, abuse or neglect of an enrollee by an employee or volunteer, loss of crisis lines, or loss of service or residential sites.
- 3.2.11.2. Notification must be made to the Mental Health Services Chief or his/her designee during the business day in which the RSN becomes aware of such an event. If the event occurs after business hours, notice must be given as soon as possible during the next business day.

- 3.2.11.3. Notification must include a description of the event, any actions taken in response to the incident, the reason any action, if any, was taken, and any implications to the service delivery system.
- 3.2.11.4. When requested, a written report must be provided within two weeks of the original notification to provide information regarding efforts designed to prevent or lessen the possibility of future similar incidents.
- 3.2.12. **Sentinel Events and Negative Media Coverage Questions (MR MSR)**
  - 3.2.12.1. Provide a written description that may include policies and procedures of the steps that will be taken to notify MHD of Sentinel events and/or negative media coverage.
  - 3.2.12.2. Describe how these events will be reviewed as part of an overall quality management process.
- 3.2.13. **Financial Requirements**
  - 3.2.13.1. For PIHP services, the Bidder must have the financial ability to accept payments on an at-risk basis and have and maintain sufficient financial resources to remain solvent and meet its contractual obligations.
  - 3.2.13.2. For State-funded services the Bidder must demonstrate that it has the ability to manage the funding to provide priority services and provide additional services within available resources.
  - 3.2.13.3. The Bidder must have and maintain risk reserves as required in Exhibit E for each Service Area. If during the contract period the Bidder has a need to spend a portion of the risk reserves, the reserve must be replenished prior to the end of the contract period. If the Bidder is a current RSN, provide the current reserve balance and the plan to replenish it prior to July 30, 2006.
  - 3.2.13.4. The Bidder must limit administration costs incurred to no more than 10 percent of available public funds supporting the public Mental Health system operated by the RSN. Categories of administrative costs are described in the BARS Manual and Supplemental Instructions. Non-public entities must use those same categories to measure administrative cost for the purposes of demonstrating compliance with the requirement and reporting to DSHS.

### **3.2.14. Financial Questions (MSR)**

3.2.14.1. Discuss and provide evidence of the Bidder's ability to accept payments and provide services on an at-risk basis and have and maintain sufficient financial resources to remain solvent and meet its obligations under any resulting contract. The materials submitted may include audited financial statements; financial statements compiled by a Certified Public Accountant in accord with Generally Accepted Accounting Principles, or financial guarantees by a county or counties. It is fully the responsibility of the Bidder to provide sufficient and convincing narrative and evidence to demonstrate financial viability.

3.2.14.2. Bidders must provide documentation that Risk Reserve requirements are met.

3.2.14.3. Provide a detailed budget for the period of September 1, 2006 through June 30, 2007. The budget must separate PIHP contract funding from State-funded contract funding and be consistent with the funding exhibits. The budget must demonstrate the Bidders ability to:

3.2.14.3.1. Provide all PIHP services

3.2.14.3.2. Provide all State-funded priority services

3.2.14.3.3. Provide State-funded services beyond priority services within available resources

3.2.14.3.4. Maintain required reserves

3.2.14.3.5. Meet requirements to limit administrative costs to ten percent measure in accord with BARS supplemental instructions.

### **3.2.15. Accounting and Internal Control Requirements**

The Bidder shall have sufficient internal controls and systems in place designed to account for Contract-related and non-Contract-related revenues and expenses separately. The Bidder must be able to ensure that all funds received by the RSN shall be accounted for by tracking Title XIX Medicaid revenue and expenditures separately from other funding sources and be reported separately as required by MHD. The RSN must ensure that all funds including interest earned, provided pursuant to the resulting contracts are used to support the public Mental Health system. In addition, the RSN must account for public Mental Health expenditures in accord with the BARS Manual and BARS Supplemental Instructions.

### **3.2.16. Accounting and Internal Control Questions (MSR)**

- 3.2.16.1. Describe the steps taken by the Bidder to implement internal control systems surrounding financial accounting and the steps taken to ensure that contract-related revenues and expenses are reported separately.
- 3.2.16.2. Identify all processes and procedures that are or will be implemented to ensure that public Mental Health expenditures are accounted for in accordance with the BARS Manual and Supplemental Instructions.
- 3.2.16.3. Submit evidence of all internal controls surrounding financial accounting, reporting including when appropriate the BARS manual and supplemental instructions.

### **3.2.17. Third Party Resources Requirements**

The RSN shall ensure a process is in place to demonstrate that all third-party resources are identified, pursued, and recorded in accordance with Medicaid being the payer of last resort. All funds recovered by the RSN from third-party resources shall be treated as income and will be used to support the public Mental Health system.

### **3.2.18. Third Party Resources Questions (MSR)**

- 3.2.18.1. Describe the methodologies that will be in place to ensure that all third-party resources are identified.
- 3.2.18.2. Describe the procedures that will be in place to ensure third party resources are pursued and that those monies are utilized to support the public Mental Health system.
- 3.2.18.3. Describe how any monies recovered from third-party payers will be recorded.

## **3.3. Information System Requirements**

### **3.3.1. Management Attestation Requirements**

- 3.3.1.1. The RSN must ensure plans or reports required by the contract are provided to MHD in compliance with the timelines and/or formats determined by MHD. Data and other fiscal information, which the contracts require the RSN to submit to MHD, shall be certified in

writing as set forth in 42 CFR 438.606. The certification shall be made by one of the following individuals:

- 3.3.1.1.1. The Chief Executive Officer (CEO).
- 3.3.1.1.2. The Chief Financial Officer (CFO).
- 3.3.1.1.3. An individual who has delegated authority to sign for, and who reports directly to the CEO or CFO.

- 3.3.1.2. The certification shall attest based on best knowledge, information, and belief as to the accuracy, completeness, and truthfulness of the documents and data. The RSN shall submit the certification concurrently with the certified data and documents.

### **3.3.2. Management Attestation Question (MR MSR)**

Provide a written description which may include policies and procedures to address management certification, including a description of how information will be submitted and will be reviewed by management to ensure accuracy prior to management's certification.

### **3.3.3. Data Requirements**

RSN shall submit all data to MHD in accordance with the current MHD-Consumer Information System CIS Data Dictionary specifications. There are two formats for data submission. Encounter Data will follow the HIPAA EDI standards described below. Other data elements must be submitted in accordance with instructions provided in the MHD-CIS Data Dictionary.

- 3.3.3.1. Health Information Portability and Accountability Act (HIPAA) format 837P is used to submit encounters for all professional (non-Institutional) services. HIPAA format 837I is used to submit encounters for most hospital services including non-hospital evaluation and treatment facilities. (HIPAA) electronic data interchange (EDI) file formats must be followed. The MHD –CIS HIPAA Trading Partner Agreement/Companion Guide is included in the MHD-CIS Data Dictionary and all provisions must be followed.
- 3.3.3.2. It is the RSN's responsibility to provide valid and usable data to MHD. To this end, the RSN shall ensure that data received from providers is accurate and complete by:
  - 3.3.3.2.1. Verifying the accuracy and timeliness of reported data.
  - 3.3.3.2.2. Screening the data for completeness, logic, and consistency.

- 3.3.3.2.3. Collecting service information in standardized formats to the extent feasible and appropriate.
- 3.3.3.2.4. Collecting service utilization data for trend analysis and benchmarking to establish long-term validity and accuracy.
- 3.3.3.3. The RSN shall submit encounters to MHD via an electronic record showing every encounter between a provider and a consumer within ~~30~~ 60 days of the close of the month in which the specific encounter occurred.
- 3.3.3.4. Data will be analyzed by MHD for accuracy and may be returned to the RSN for resubmission. In the event the data is rejected an explanation for the disallowance will be provided. The RSN must develop error handling process that includes correction of the erroneous data and resubmission capabilities. The RSN must also require subcontractors to develop error handling processes that include correction of the erroneous data and resubmission capabilities.

#### **3.3.4. Data Questions (MR MSR)**

- 3.3.4.1. Describe the Bidders Electronic Data Interchange environment including services and processes for creating, verifying, and sending encounters, including encounters submitted by subcontractors.
- 3.3.4.2. Provide copies of submission reports that have been generated during an encounter submission process.
- 3.3.4.3. Provide examples of subcontract claims lag reports that demonstrate how subcontractor claims (if applicable) are paid and that encounters will be submitted to MHD within ~~30~~ 60 days of the close of the calendar month in which the encounter occurred.
- 3.3.4.4. Provide a written description of processes that will be used for error resolution and encounter resubmission both from subcontractors to the Bidder and from the Bidder to MHD.
- 3.3.4.5. Describe how the Bidder will measure and report outcomes for the requirements.

### **3.3.5. Enrollment and Demographic Data Requirements**

- 3.3.5.1. RSN shall receive client eligibility and demographic information in accordance with current CIS specifications.
- 3.3.5.2. The RSN must be able to receive electronic Medicaid eligibility information that will be used to establish or terminate a client's eligibility for Medicaid mental health services. RSN must also be able to process retroactive changes in a client's status. Claims affected by eligibility retroactivity must be re-processed based on the new client status.
- 3.3.5.3. The RSN must be able to modify their information systems within 120 days of the date of published changes to the MHD-CIS Data Dictionary. If the RSN uses an independent vendor to make changes, the vendor must have the ability to make required changes within the timeframe.

### **3.3.6. Enrollment and Demographic Data Questions (~~MR~~ MSR)**

- 3.3.6.1. Provide documentation that may include policies and procedures to describe how the Bidder will meet the requirement to modify their information systems within 120 days of the date of published changes to the MHD-CIS Data Dictionary. If the Bidder uses an independent vendor to make changes, supply documentation that describes the vendor's agreement and ability to make required changes within contracted timeframes.

### **3.3.7. Reporting Requirements**

The RSN shall maintain an information system that supports the management and oversight of Medicaid waiver and State-funded services. The RSN shall maintain an information system that collects, analyzes, integrates, and reports data. The system shall provide information on areas such as utilization, grievances and appeals, and encounter submission information. The RSN must have a system disaster recovery plan.

### **3.3.8. Reporting Questions (MSR)**

- 3.3.8.1. Provide a description of the data reporting environment including data repositories and system diagrams.
- 3.3.8.2. Provide encounter submission reports that show number of records sent and accepted by the Bidder's information system from subcontractors.

- 3.3.8.3. Describe how security of the data, systems, and software is achieved.
- 3.3.8.4. Provide a written description that may include policies and procedures of the process that will be used to ensure system recoverability both for the Bidder's information systems and for those of subcontractors.
- 3.3.8.5. Provide written description that may include policies and procedures of the process that will be used for providing a primary and backup system for electronic submission of data to MHD.
- 3.3.8.6. Provide written description that may include policies and procedures that address how bidders' information system will be used as part of utilization review and resource management.
- ~~3.3.8.7. Provide documentation that describes how the Bidder will meet the requirement to modify their information systems within 120 days of the date of published changes to the MHD-CIS Data Dictionary. If the Bidder uses an independent vendor to make changes, supply documentation that describes the vendor's agreement and ability to make required changes within contracted timeframes.~~

#### **3.4. RSN Program Requirements**

##### **3.4.1. Disaster Proposal Requirements**

The RSN must participate in all disaster preparedness activities and respond to emergency/disaster events when requested by MHD. The RSN shall:

- 3.4.1.1. Attend MHD-sponsored training regarding the role of the public mental health system in disaster preparedness and proposal.
- 3.4.1.2. Participate in local emergency/disaster planning activities when county Emergency Operation Centers and local public health jurisdictions request collaboration.
- 3.4.1.3. Provide disaster outreach, as defined herein and as required in the State-funded Contract, for the RSN's Service Area in the event of a disaster/emergency.
- 3.4.1.4. Conduct post-disaster outreach to determine the need for disaster related crisis counseling and assess the availability of local resources in meeting those needs.

- 3.4.1.5. Provide the name and contact information to MHD for person(s) coordinating the RSN disaster/emergency preparedness and proposal upon request.

Provide information and preliminary disaster proposal plans to MHD within 7 days following a disaster/emergency or upon request.

- 3.4.1.6. Partner in disaster preparedness and proposal activities with MHD and other DSHS entities, the State Emergency Management Division, FEMA, the American Red Cross and other volunteer organizations. This must include:

- 3.4.1.6.1. Participation when requested in local and regional disaster planning and preparedness activities.

- 3.4.1.6.2. Coordination of disaster outreach activities following an event.

#### **3.4.2. Disaster Proposal Questions (~~MR~~ MSR)**

- 3.4.2.1. Provide the name and contact information of the lead staff for Disaster Proposal.

- 3.4.2.2. Describe how the Bidder will provide the services and activities outlined in the previous section.

- 3.4.2.3. Describe how the Bidder will measure and report outcomes for the requirements.

#### **3.4.3. General Information Requirements**

- 3.4.3.1. The RSN shall provide to persons served by the RSN information on the following topics, either through the Medicaid Benefits Booklet or RSN produced materials:

- 3.4.3.1.1. Access to Care

- 3.4.3.1.2. Covered Title XIX and State-funded Services

- 3.4.3.1.3. Consumer/Member Service Contact Information

- 3.4.3.1.4. Provider Network

- 3.4.3.1.5. Grievance, Appeals and Fair Hearings Rights

- 3.4.3.1.6. Ombuds Program

3.4.3.1.7. Consumer Rights

3.4.3.1.8. Signs of Mental Illness

3.4.3.1.9. Availability of written materials in alternative formats and how to access those formats

3.4.3.2. In addition to English, the RSN shall provide the information described above in the following prevalent languages:

3.4.3.2.1. Cambodian

3.4.3.2.2. Chinese

3.4.3.2.3. Korean

3.4.3.2.4. Laotian

3.4.3.2.5. Russian

3.4.3.2.6. Spanish

3.4.3.2.7. Vietnamese

3.4.3.3. The RSN shall:

3.4.3.3.1. Provide written materials in easily understood language and format, including alternative formats.

3.4.3.3.2. Post client rights in the languages set forth above.

3.4.3.3.3. Provide access to written interpretation of all consumer materials.

3.4.3.3.4. Provide access to these materials prior to conducting an intake evaluation.

**3.4.4. General Information Questions (MR MSR)**

3.4.4.1. Provide a written description that may include policies and procedures that address all the general information requirements as stated above.

- 3.4.4.2. Provide sufficient narrative to demonstrate the Bidders understanding of and compliance with the general information requirements.

#### **3.4.5. For Title XIX Enrollees - Special Information Requirements**

The RSN shall provide the following written notice for Title XIX enrollees.

- 3.4.5.1. Make a good faith effort to give written notice of termination of a Mental Health Care Provider (MHCP), within 15 days after receipt or issuance of the termination notice, to each enrollee who received his or her primary care from, or was seen on a regular basis by, the MHCP.
- 3.4.5.2. Notice of Action and information on grievances, appeal and fair hearing procedures and timeframes that are in compliance with the Grievance system general requirements of the proposed contract.

#### **3.4.6. For Title XIX Enrollees - Special Information Questions (MR MSR)**

- 3.4.6.1. Describe the process for notifying Title XIX enrollees of termination of a MHCP.
- 3.4.6.2. Describe the process and procedures for issuing a Notice of Action for Title XIX enrollees. Describe how written information is or will be provided to enrollees about the grievance, appeals and fair hearing procedures and time frames that are in compliance with the Grievance system general requirements of the proposed contract.

#### **3.4.7. Title XIX Services Requirements**

- 3.4.7.1. The RSN must have the administrative capacity and organizational stability to operate as a PIHP and to administer medically necessary Mental Health services to enrollees pursuant to:
  - 3.4.7.1.1. 42 CFR 438, or any successors and Federal 1915 (b) Mental Health Waiver, Medicaid State plan or any successors.
  - 3.4.7.1.2. Other provisions of Title XIX of the Social Security Act, or any successors.
  - 3.4.7.1.3. RCW 38.52, 70.02, 71.05, 71.24, and 71.34, or any successors; WAC 388-865 or any successors.
  - 3.4.7.1.4. Washington Administrative Code Chapter 388-865 or any successors.

- 3.4.7.1.5. Other applicable State and federal statutes and regulations, or any successors.
- 3.4.7.2. The RSN shall have adequate professional staff in place to perform all Title XIX Service requirements.
- 3.4.7.3. The RSN is required to provide services that assist enrollees' progress toward recovery and resiliency and promotes linkages to other formal and informal systems of care.
- 3.4.7.4. Enrollees must have access to the following benefits based on the Medicaid State Plan prior to an intake evaluation:
  - 3.4.7.4.1. Crisis Services
  - 3.4.7.4.2. Psychiatric Inpatient Services and Evaluation and Treatment
  - 3.4.7.4.3. Stabilization; and Rehabilitation Case Management
- 3.4.7.5. All Medicaid enrollees requesting mental health services must be offered an intake evaluation as defined in the Medicaid State Plan. A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services.
- 3.4.7.6. Authorization for further services must be based on medical necessity and the Access to Care Standards. Enrollees denied an intake evaluation must receive a Notice of Action from the PIHP or its formal designee.
- 3.4.7.7. Mental Health Rehabilitation Services are integrated treatment services recommended by a mental health professional and furnished by State licensed Community Mental Health Agencies, except for Mental Health Clubhouse. Services are provided to seriously mentally ill adults and seriously emotionally disturbed children for whom the services are determined to be medically necessary. Services shall be provided based on the following definitions, requirements and standards from the Medicaid State Plan or the 1915(b)(3) Waiver:
  - 3.4.7.7.1. Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-

treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the Medicaid enrollee's Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the enrollee's current level of functioning and assistance with self/care or life skills training. Enrollees may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

- 3.4.7.7.2. Crisis Services: Evaluation and treatment of mental health crisis to all Medicaid enrolled individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.
- 3.4.7.7.3. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management) for Medicaid enrollees to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. Eligible individuals must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a

location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available 5 hours per day, 5 days per week.

- 3.4.7.7.4. Family Treatment: Psychological counseling provided for the direct benefit of a Medicaid enrolled individual. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.
- 3.4.7.7.5. Freestanding Evaluation and Treatment: Services provided in freestanding inpatient residential (non-hospital/non-IMD) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to the Medicaid enrolled individual who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to: performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.

This service is provided for individuals who pose an actual or imminent danger to self, others, or property due to a mental illness, or who have experienced a marked decline in their

ability to care for self due to the onset or exacerbation of a psychiatric disorder.

The severity of symptoms, intensity of treatment needs or lack of necessary supports for the individual does not allow them to be managed at a lesser level of care. This service does not include cost for room and board.

The Mental Health Division must authorize exceptions for involuntary length of stay beyond a fourteen-day commitment.

- 3.4.7.7.6. Group Treatment Services: Services provided to Medicaid enrolled individuals designed to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more Medicaid enrolled individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.
- 3.4.7.7.7. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to Medicaid enrolled individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, and neighbor). Other community agency members may include probation/parole officers\*, teacher, minister, physician, chemical dependency counselor\*, etc. Team members work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

Billable components of this modality include time spent by the mental health professionals, mental health care providers and peer counselors.

\*Although they participate, these team members are paid staff of other Departments and therefore not reimbursed under this modality.

3.4.7.7.8. Individual Treatment Services: A set of treatment services designed to help a Medicaid enrolled individual attain goals as prescribed in their individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the Medicaid enrolled individual. This service is provided by or under the supervision of a mental health professional.

3.4.7.7.9. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization

services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

- 3.4.7.7.10. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.
- 3.4.7.7.11. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging a Medicaid enrolled individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services for the direct benefit of the Medicaid enrolled individual. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Enrollees with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional. Time spent with the enrollee is the only direct service billable component of this modality.
- 3.4.7.7.12. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital/non IMD) that offers a sub-acute psychiatric management environment. Medicaid enrolled individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care to a

Medicaid enrollee. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. This service is billable on a daily rate. In order to bill the daily rate for associated costs for these services, a minimum of 8 hours of service must be provided. This service does not include the costs for room and board, custodial care, and medical services, and differs for other services in the terms of location and duration.

- 3.4.7.7.13. Peer Support: Services provided by peer counselors to Medicaid enrolled individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer including Medicaid eligibility.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

3.4.7.7.14. Psychiatric Inpatient Services: 24-hour beds for psychiatric services.

3.4.7.7.14.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300.

3.4.7.7.14.2. Develop, maintain or purchase services for individuals who are involuntarily detained or committed in non-IMD community hospitals or evaluation and treatment facilities in accordance with RCW 71.05 or 71.34.

3.4.7.7.14.3. Provide or purchase psychiatric inpatient services when it is determined to be medically necessary for the following Title XIX eligible individuals:

3.4.7.7.14.3.1. Individuals under 22 years of age and over 64 years of age admitted to an Institute for Mental Disease (IMD).

3.4.7.7.14.3.2. Individuals who are voluntarily admitted to non-IMD community hospitals or evaluation and treatment facilities.

3.4.7.7.15. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall: be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.

3.4.7.7.16. Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility for the direct benefit of a Medicaid-enrolled individual in the public mental health system. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include

assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned re-admission and to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

- 3.4.7.7.17. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake. Consultation from a non-staff specialist (employed by another CMHA or contracted by the CMHA) may also be obtained, if needed, subsequent to this evaluation and shall be considered an integral, billable component of this service.
- 3.4.7.7.18. Stabilization Services: Services provided to Medicaid enrolled individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.
- 3.4.7.7.19. Therapeutic Psychoeducation: Informational and experiential services designed to aid Medicaid enrolled individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the

Medicaid enrolled individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional. Classroom style teaching, family treatment and individual treatment are not billable components of this service.

- 3.4.7.7.20. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary care givers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional. Respite under this waiver is only available to those consumers who do not have this coverage under some other federal program.
- 3.4.7.7.21. Supported Employment: A service for Medicaid enrollees who are neither currently receiving nor who are on a waiting list to receive federally funded vocational services such as those provided through the Department of Vocational Rehabilitation. Services will include:

- 3.4.7.7.21.1. An assessment of work history, skills, training, education, and personal career goals.
- 3.4.7.7.21.2. Information about how employment will affect income and benefits the consumer is receiving because of their disability.
- 3.4.7.7.21.3. Preparation skills such as resume development and interview skills.
- 3.4.7.7.21.4. Involvement with consumers served in creating and revising individualized job and career development plans that include:
  - 3.4.7.7.21.4.1. Consumer strengths
  - 3.4.7.7.21.4.2. Consumer abilities
  - 3.4.7.7.21.4.3. Consumer preferences
  - 3.4.7.7.21.4.4. Consumer's desired outcomes
- 3.4.7.7.21.5. Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.
- 3.4.7.7.21.6. Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- 3.4.7.7.21.7. Services are provided by or under the supervision of a mental health professional.
- 3.4.7.7.22. Mental Health Clubhouse: A service specifically contracted by the PIHP to provide a consumer directed program to Medicaid enrollees where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:

- 3.4.7.7.22.1. Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.
- 3.4.7.7.22.2. Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.
- 3.4.7.7.22.3. Assistance with employment opportunities; housing, transportation, education and benefits planning.
- 3.4.7.7.22.4. Operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday.
- 3.4.7.7.22.5. Opportunities for socialization activities.

#### **3.4.8. Title XIX Services Questions (MSR)**

- 3.4.8.1. Provide a description that may include policies and procedures of how the Bidder will assist the enrollee's progress toward recovery and resiliency and promote linkages to other formal and informal systems. Include sufficient narrative to illustrate the ~~RSN's~~ Bidder's understanding of and compliance with the requirement.
- 3.4.8.2. Provide a detailed description that may include but is not limited to, written policies and procedures that addresses how the Bidder will provide enrollees access to each of the following benefits prior to an intake evaluation. Describe in detail how **each** of the listed services will be provided including facilities, staffing, staff qualifications and sufficient narrative to illustrate the Bidders understanding of service requirements and compliance with the requirements:
  - 3.4.8.2.1. Crisis Services
  - 3.4.8.2.2. Psychiatric Inpatient Services and Evaluation and Treatment
  - 3.4.8.2.3. Stabilization; and Rehabilitation Case Management
- 3.4.8.3. Provide a written description, that may include but is not limited to, policies and procedures that address how the Bidder will offer and provide Medicaid enrollees requesting covered mental health services an intake evaluation within 10 days of a request for mental health services. Include sufficient narrative to illustrate the ~~RSN's~~ Bidder's understanding of and compliance with the requirement.

A request for mental health services is defined as a point in time when mental health services are sought or applied for through a telephone call, EPSDT referral, walk-in, or written request for mental health services.

- 3.4.8.4. Provide written a written description that may include policies and procedures, that address how the Bidder will authorize services following an intake evaluation. The authorization must be based on medical necessity and the Access to Care Standards. Describe the process for enrollees denied an intake evaluation to receive a Notice of Action from the PIHP or its formal designee. Describe how denials will be tracked. Include sufficient narrative to illustrate the Bidders understanding of and compliance with these requirements.
- 3.4.8.5. Provide a written description that may include policies and procedures that address how the Bidder will provide Mental Health Rehabilitation Services that are integrated treatment services, recommended by a mental health professional, furnished by State licensed Community Mental Health Agencies, and provided to older adults, adults and children for whom the services are determined to be medically necessary.

Describe in detail how each service described under 3.4.7.7. (3.4.7.7.1. to 3.4.7.7.22, excluding those that are addressed in question 3.4.8.2) will be provided. For each service, include locations facilities, staffing, staff qualifications and sufficient narrative to illustrate the Bidders understanding of the each service, including the service requirements.

#### **3.4.9. State-funded Program Services Requirements**

##### **3.4.9.1. Priority State-funded Services**

RSNs must have the administrative capacity and organizational stability to provide or purchase age, linguistic and culturally competent and community Mental Health services for individuals for whom services are medically necessary and clinically appropriate pursuant to:

- 3.4.9.1.1. RCW 38.52, 70.02, 71.05, 71.24, and 71.34, or any successors;
- 3.4.9.1.2. Washington Administrative Code Chapter 388-865 or any successors.

- 3.4.9.1.3. Other applicable State and federal statutes and regulations, or any successors.
- 3.4.9.2. The Bidder shall have adequate professional staff in place to perform all functions required in the State-funded Services Requirements.
- 3.4.9.3. The RSN is required to prioritize the use of available State funds to provide the following services:
  - 3.4.9.3.1. Crisis Services: Evaluation and treatment of mental health crisis to all individuals experiencing a crisis. A mental health crisis is defined as a turning point in the course of anything decisive or critical, a time, a stage, or an event or a time of great danger or trouble, whose outcome decides whether possible bad consequences will follow. Crisis services shall be available on a 24-hour basis. Crisis Services are intended to stabilize the person in crisis, prevent further deterioration and provide immediate treatment and intervention in a location best suited to meet the needs of the individual and in the least restrictive environment available. Crisis services may be provided prior to completion of an intake evaluation. Services are provided by or under the supervision of a mental health professional.
  - 3.4.9.3.2. Stabilization Services: Services to individuals who are experiencing a mental health crisis. These services are to be provided in the person's own home, or another home-like setting, or a setting which provides safety for the individual and the mental health professional. Stabilization services shall include short-term (less than two weeks per episode) face-to-face assistance with life skills training, and understanding of medication effects. This service includes: a) follow up to crisis services; and b) other individuals determined by a mental health professional to need additional stabilization services. Stabilization services may be provided prior to an intake evaluation for mental health services.
  - 3.4.9.3.3. Involuntary Treatment Act Services: Includes all services and administrative functions required for the evaluation for involuntary detention or involuntary treatment of individuals in accordance with RCW 71.05 and 71.34, 71.24.300. This includes all evaluation and monitoring services, costs related to court processes and transportation. ~~Prior to September 1,~~

~~2006, the bidder must be able to execute a written agreement with all counties within the boundaries of the Service Area in which involuntary treatment court processes are conducted which clarifies the responsibilities of the bidder and the responsibilities of the county in terms of involuntary treatment act court processes.~~ Crisis Services become Involuntary Treatment Act Services when a Designated Mental Health Professional determines an individual must be evaluated for involuntary treatment. ITA services continue until the end of the involuntary commitment.

- 3.4.9.3.4. Ancillary Crisis Services: Includes costs associated with providing medically necessary crisis services not included in the Medicaid State Plan. Costs include but are not limited to the cost of room and board in hospital diversion settings or in freestanding Evaluation and Treatment facilities.
- 3.4.9.3.5. Freestanding Evaluation and Treatment: Services provided in inpatient residential (non-hospital) facilities licensed by the Department of Health and certified by the Mental Health Division to provide medically necessary evaluation and treatment to individuals who would otherwise meet hospital admission criteria. These are not-for-profit organizations. At a minimum, services include evaluation, stabilization and treatment provided by or under the direction of licensed psychiatrists, nurses and other mental health professionals, and discharge planning involving the individual, family, significant others so as to ensure continuity of mental health care. Nursing care includes but is not limited to; performing routine blood draws, monitoring vital signs, providing injections, administering medications, observing behaviors and presentation of symptoms of mental illness. Treatment modalities may include individual and family therapy, milieu therapy, psycho-educational groups and pharmacology. The individual is discharged as soon as a less-restrictive plan for treatment can be safely implemented.
- 3.4.9.3.6. Psychiatric Inpatient Services: 24-hour beds for psychiatric services.
  - 3.4.9.3.6.1. Develop, maintain or purchase Involuntary Treatment Act (ITA) certified treatment beds to meet the statutory requirements of RCW 71.24.300.

3.4.9.3.6.2. Develop, maintain or purchase services for individuals who are involuntarily detained or committed in community hospitals or evaluation and treatment facilities in accordance with RCW 71.05 or 71.34 and who are eligible under General Assistance-Unemployable (GA-U), or who are not eligible for any other medical assistance program.

3.4.9.3.6.3. Provide or purchase psychiatric inpatient services when it is determined to be medically necessary for:

3.4.9.3.6.3.1. Individuals who agree to be admitted voluntarily and who are beneficiaries of the following State-funded assistance programs: Psychiatric Indigent Inpatient (PII) and General Assistance Unemployable (GA-U).

3.4.9.3.6.3.2. Individuals at least 22 years of age and under 65 years of age who are Medicaid enrollees and are admitted to an Institute for Mental Disease (IMD).

3.4.9.3.7. Medicaid Personal Care: Respond to requests for Medicaid Personal Care (MPC) from the DSHS Aging and Disability Services Administration (ADSA) within 5 working days of the request. ADSA will use the Comprehensive Assessment Reporting Evaluation (CARE) tool to determine service needed. The RSN may not limit or restrict authorization for these services due to insufficient resources. Authorization decisions must be based on the following:

3.4.9.3.7.1. A review of the request to determine if the individual is currently authorized to receive services from the Prepaid Inpatient Health Plan in the RSN's Service Area.

3.4.9.3.7.2. A verification that need for MPC services is based solely on the presence of a psychiatric disability.

3.4.9.3.7.3. A review of the requested MPC services to determine if the individual's needs could be met through provision of other available RSN services.

#### 3.4.9.4. Additional State-funded Services

The RSN is required to prioritize any remaining funds following the provision of the Priority State-funded Services above to provide the following:

#### 3.4.9.4.1. Residential Programs:

- 3.4.9.4.1.1. The full range of residential settings and programs must be available and provided based on the individuals needs, medical necessity and within available resources per the RSN's policies and procedures. The RSN must have contracts or memorandums of understanding to purchase a residential program outside of the RSN's Service Area when an individual requires a level of residential support which is not available from the RSN.
- 3.4.9.4.1.2. The full range of residential programs and settings include the following:
  - 3.4.9.4.1.2.1. Long-term intensive adaptive and rehabilitative psychiatric care such as is provided in Adult Residential Rehabilitation Centers.
  - 3.4.9.4.1.2.2. Supervised living such as residential programs developed to serve individuals diagnosed with a major mental illness in Skilled Nursing Facilities, boarding homes or adult family homes.
  - 3.4.9.4.1.2.3. Supported housing services such as intensive services provided to maintain individuals in unlicensed individual or group home settings including transitional or permanent housing.

#### 3.4.9.4.2. Outpatient Mental Health Services

The descriptions and standards for State-funded outpatient services are below.

- 3.4.9.4.2.1. Brief Intervention Treatment: Solution focused and outcomes oriented cognitive and behavioral interventions intended to ameliorate symptoms, resolve situational disturbances which are not amenable to resolution in a crisis service model of care and which do not require long term-treatment, to return the individual to previous higher levels of general functioning. Individuals must be able to select and identify a focus for care that is consistent with time-limited, solution-focused or cognitive-behavioral model of treatment. Functional problems and/or needs identified in the

Individual Service Plan must include a specific time frame for completion of each identified goal. This service does not include ongoing care, maintenance/monitoring of the current level of functioning and assistance with self/care or life skills training. Individuals may move from Brief Intervention Treatment to longer term Individual Services at any time during the course of care. This service is provided by or under the supervision of a Mental Health Professional.

3.4.9.4.2.2. Day Support: An intensive rehabilitative program which provides a range of integrated and varied life skills training (e.g., health, hygiene, nutritional issues, money management, maintaining living arrangement, symptom management, to promote improved functioning or a restoration to a previous higher level of functioning. The program is designed to assist the individual in the acquisition of skills, retention of current functioning or improvement in the current level of functioning, appropriate socialization and adaptive coping skills. To receive this service an Individual must demonstrate restricted functioning as evidenced by an inability to provide for their instrumental activities of daily living. This modality may be provided as an adjunctive treatment or as a primary intervention. The staff to consumer ratio is no more than 1:20 and is provided by or under the supervision of a mental health professional in a location easily accessible to the client (e.g., community mental health agencies, clubhouses, community centers). This service is available up to 5 hours per day, 5 days per week.

3.4.9.4.2.3. Family Treatment: Psychological counseling provided for the direct benefit of the individual receiving services. Service is provided with family members and/or other relevant persons in attendance as active participants. Treatment shall be appropriate to the culture of the client and their family and should reinforce the family structure, improve communication and awareness, enforce and reintegrate the family structure within the community, and reduce the family crisis/upheaval. The treatment will provide family-centered interventions to identify and address family dynamics and build competencies to strengthen family functioning in relationship to the consumer. Family treatment may

take place without the consumer present in the room but service must be for the benefit of attaining the goals identified for the individual in their individual service plan. This service is provided by or under the supervision of a mental health professional.

3.4.9.4.2.4. Group Treatment Services: Services provided to assist in the attainment of goals described in the Individual Service Plan. Goals of Group Treatment may include developing self care and/or life skills, enhancing interpersonal skills, mitigating the symptoms of mental illness, and lessening the results of traumatic experiences, learning from the perspective and experiences of others and counseling/psychotherapy to establish and /or maintain stability in living, work or educational environment. Individuals eligible for Group Treatment must demonstrate an ability to benefit from experiences shared by others, demonstrate the ability to participate in a group dynamic process in a manner that is respectful of other's right to confidential treatment and must be able to integrate feedback from other group members. This service is provided by or under the supervision of a mental health professional to two or more individuals at the same time. Staff to consumer ratio is no more than 1:12. Maximum group size is 24.

3.4.9.4.2.5. High Intensity Treatment: Intensive levels of service otherwise furnished under this State plan amendment that is provided to individuals who require a multi-disciplinary treatment team in the community that is available upon demand based on the individual's need. Twenty-four hours per day, seven days per week, access is required if necessary. Goals for High Intensity Treatment include the reinforcement of safety, the promotion of stability and independence of the individual in the community, and the restoration to a higher level of functioning. These services are designed to rehabilitate individuals who are experiencing severe symptoms in the community and thereby avoid more restrictive levels of care such as psychiatric inpatient hospitalization or residential placement.

The team consists of the individual, Mental Health Care Providers, under the supervision of a mental health

professional, and other relevant persons as determined by the individual (e.g., family, guardian, friends, and neighbor). Other community agency members may include probation/parole officers, teacher, minister, physician, chemical dependency counselor, etc. Team member's work together to provide intensive coordinated and integrated treatment as described in the individual service plan. The team's intensity varies among individuals and for each individual across time. The assessment of symptoms and functioning will be continuously addressed by the team based on the needs of the individual allowing for the prompt assessment for needed modifications to the individual service plan or crisis plan. Team members provide immediate feedback to the individual and to other team members. The staff to consumer ratio for this service is no more than 1:15.

3.4.9.4.2.6. Individual Treatment Services: A set of treatment services designed to help a attain goals as prescribed an individual treatment plan. These services shall be congruent with the age, strengths, and cultural framework of the individual and shall be conducted with the individual, his or her family, or others at the individual's behest who play a direct role in assisting the individual to establish and/or maintain stability in his/her daily life. These services may include, developing the individual's self-care/life skills; monitoring the individual's functioning; counseling and psychotherapy. Services shall be offered at the location preferred by the individual. This service is provided by or under the supervision of a mental health professional.

3.4.9.4.2.7. Intake Evaluation: An evaluation that is culturally and age relevant initiated prior to the provision of any other mental health services, except crisis services, services, stabilization services and free-standing evaluation and treatment. The intake evaluation must be initiated within ten (10) working days of the request for services, establish the medical necessity for treatment and be completed within thirty (30) working days. Routine services may begin before the completion of the intake once medical necessity is established. This service is provided by a mental health professional.

- 3.4.9.4.2.8. Medication Management: The prescribing and/or administering and reviewing of medications and their side effects. This service shall be rendered face-to-face by a person licensed to perform such services. This service may be provided in consultation with collateral, primary therapists, and/or case managers, but includes only minimal psychotherapy.
- 3.4.9.4.2.9. Medication Monitoring: Face-to-face one-on-one cueing, observing, and encouraging an individual to take medications as prescribed. Also includes reporting back to persons licensed to perform medication management services. This activity may take place at any location and for as long as it is clinically necessary. This service is designed to facilitate medication compliance and positive outcomes. Individuals with low medication compliance history or persons newly on medication are most likely to receive this service. This service is provided by or under the supervision of a mental health professional.
- 3.4.9.4.2.10. Mental Health Clubhouse: A service specifically contracted by the RSN to provide a consumer directed program to individuals where they receive multiple services. These services may be in the form of support groups, related meetings, consumer training, peer support, etc. Consumers may drop in on a daily basis and participate, as they are able. Mental Health Clubhouses are not an alternative for day support services. Clubhouses must use the International Center for Clubhouse Development (ICCD) standards as guidelines. Services include the following:
- 3.4.9.4.2.10.1. Opportunities to work within the clubhouse, which contributes to the operation and enhancement of the clubhouse community.
  - 3.4.9.4.2.10.2. Opportunities to participate in administration, public relations, advocacy and evaluation of clubhouse effectiveness.
  - 3.4.9.4.2.10.3. Assistance with employment opportunities; housing, transportation, education and benefits planning.

3.4.9.4.2.10.4. Operate at least ten hours a week after 5:30 p.m., Monday through Friday, or anytime on Saturday or Sunday.

3.4.9.4.2.10.5. Opportunities for socialization activities.

3.4.9.4.2.11. Mental Health Services provided in Residential Settings: A specialized form of rehabilitation service (non hospital) that offers a sub-acute psychiatric management environment. Individuals receiving this service present with severe impairment in psychosocial functioning or has apparent mental illness symptoms with an unclear etiology due to their mental illness and treatment cannot be safely provided in a less restrictive environment and do not meet hospital admission criteria. Individuals in this service require a different level of service than High Intensity Treatment. The Mental Health Care Provider is sited at the residential location (e.g., boarding homes, supported housing, cluster housing, SRO apartments) for extended hours to provide direct mental health care. Therapeutic interventions both in individual and group format may include medication management and monitoring, stabilization, and cognitive and behavioral interventions designed with the intent to stabilize the individual and return him/her to more independent and less restrictive treatment. The treatment is not for the purpose of providing custodial care or respite for the family, nor is it for the sole purpose of increasing social activity or used as a substitute for other community-based resources. A minimum of 8 hours of service must be provided.

3.4.9.4.2.12. Peer Support: Services provided by peer counselors to individuals under the consultation, facilitation or supervision of a mental health professional who understands rehabilitation and recovery. This service provides scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills. Consumers actively participate in decision-making and the operation of the programmatic supports.

Self-help support groups, telephone support lines, drop-in centers, and sharing the peer counselor's own life experiences related to mental illness will build alliances that enhance the consumer's ability to

function in the community. These services may occur at locations where consumers are known to gather (e.g., churches, parks, community centers, etc). Drop-in centers are required to maintain a log documenting identification of the consumer.

Services provided by peer counselors to the consumer are noted in the consumers' Individualized Service Plan which delineates specific goals that are flexible tailored to the consumer and attempt to utilize community and natural supports. Monthly progress notes document consumer progress relative to goals identified in the Individualized Service Plan, and indicates where treatment goals have not yet been achieved.

Peer counselors are responsible for the implementation of peer support services. Peer counselors may serve on High Intensity Treatment Teams.

Peer support is available daily no more than four hours per day. The ratio for this service is no more than 1:20.

- 3.4.9.4.2.13. Psychological Assessment: All psychometric services provided for evaluating, diagnostic, or therapeutic purposes by or under the supervision of a licensed psychologist. Psychological assessments shall be culturally relevant; provide information relevant to a consumer's continuation in appropriate treatment; and assist in treatment planning within a licensed mental health agency.
- 3.4.9.4.2.14. Rehabilitation Case Management: A range of activities by the outpatient community mental health agency's liaison conducted in or with a facility. To be eligible, the individual must be in need of case management in order to ensure timely and appropriate treatment and care coordination. Activities include assessment for discharge or admission community to mental health care, integrated mental health treatment planning, resource identification and linkage, to mental health rehabilitative services, and collaborative development of individualized services that promote continuity of mental health care. These specialized mental health coordination activities are intended to promote discharge, to maximize the benefits of the placement, and to minimize the risk of unplanned readmission and

to increase the community tenure for the individual. Services are provided by or under the supervision of a mental health professional.

- 3.4.9.4.2.15. Respite Care: A service to sustain the primary caregivers of children with serious or emotional disorders or adults with mental illness. This is accomplished by providing observation, direct support and monitoring to meet the physical, emotional, social and mental health needs of an individual consumer by someone other than the primary caregivers. Respite care should be provided in a manner that provides necessary relief to caregivers. Respite may be provided on a planned or an emergent basis and may be provided in a variety of settings such as in the consumer or caregiver's home, in an organization's facilities, in the respite worker's home, etc. The care should be flexible to ensure that the individual's daily routine is maintained. Respite is provided by, or under the supervision of, a mental health professional.
- 3.4.9.4.2.16. Special Population Evaluation: Evaluation by a child, geriatric, disabled, or ethnic minority specialist that considers age and cultural variables specific to the individual being evaluated and other culturally and age competent evaluation methods. This evaluation shall provide information relevant to a consumer's continuation in appropriate treatment and assist in treatment planning. This evaluation occurs after intake.
- 3.4.9.4.2.17. Supported Employment: Services will include:
  - 3.4.9.4.2.17.1. An assessment of work history, skills, training, education, and personal career goals.
  - 3.4.9.4.2.17.2. Information about how employment will affect income and benefits the consumer is receiving because of their disability.
  - 3.4.9.4.2.17.3. Preparation skills such as resume development and interview skills.
  - 3.4.9.4.2.17.4. Involvement with consumers served in creating and revising individualized job and career development plans that include:

- 3.4.9.4.2.17.4.1. Consumer strengths
- 3.4.9.4.2.17.4.2. Consumer abilities
- 3.4.9.4.2.17.4.3. Consumer preferences
- 3.4.9.4.2.17.4.4. Consumer's desired outcomes
- 3.4.9.4.2.17.5. Assistance in locating employment opportunities that is consistent with the consumer's strengths abilities, preferences, and desired outcomes.
- 3.4.9.4.2.17.6. Integrated supported employment, including outreach/job coaching and support in a normalized or integrated work site, if required.
- 3.4.9.4.2.17.7. Services are provided by or under the supervision of a mental health professional.
- 3.4.9.4.2.18. Therapeutic Psychoeducation: Informational and experiential services designed to aid individuals, their family members (e.g., spouse, parents, siblings) and other individuals identified by the individual as a primary natural support, in the management of psychiatric conditions, increased knowledge of mental illnesses and understanding the importance of their individual plan of care. These services are exclusively for the benefit of the individual and are included in the Individual Service Plan.

The primary goal is to restore lost functioning and promote reintegration and recovery through knowledge of one's disease, the symptoms, precautions related to decompensation, understanding of the "triggers" of crisis, crisis planning, community resources, successful interrelations, medication action and interaction, etc. Training and shared information may include brain chemistry and functioning; latest research on mental illness causes and treatments; diagnostics; medication education and management; symptom management; behavior management; stress management; crisis management; improving daily living skills; independent living skills; problem-solving skills, etc.

Services are provided at locations convenient to the consumer, by or under the supervision of a mental health professional.

#### **3.4.10. State-funded Services Questions (MSR)**

- 3.4.10.1. Provide a written description, including any existing policies and procedures that address how the Bidder will provide Priority State-funded Services. Describe in detail how each service will be provided including facilities, staffing and staff qualifications. Provide sufficient narrative to illustrate the Bidders understanding of each service and understanding of the service requirements. ~~Include copies of any memoranda of understanding with counties which provide involuntary treatment act court processes. If these memoranda of understanding have not been developed or are provided as drafts, provide a plan for developing and executing these agreements by September 1, 2006.~~
- 3.4.10.2. Provide a written description, including any existing policies and procedures that address how the Bidder will prioritize any remaining state funding for ~~provide the~~ Additional State-funded Services. Identify the additional services and describe in detail how **each** prioritized service will be provided including facilities, staffing, and staff qualifications. Provide sufficient narrative to illustrate the Bidders understanding of the service requirements.
- 3.4.10.3. Provide sufficient narrative and budget detail to fully describe how the ~~RSN~~ Bidder is allocating and prioritizing State only funding, local funding and services. Fully explain the rational and methodology for ~~RSN~~ Bidders decisions.

#### **3.4.11. Customer Service Requirements**

The RSN shall provide Customer Service that is customer friendly, flexible, proactive, and responsive to consumers, families, and stakeholders. Customer Service staff shall:

- 3.4.11.1. Answer customer service lines via both local and toll free numbers from 8:00 a.m. until 5:00 p.m. Monday through Friday, state holidays excluded.
- 3.4.11.2. Respond to benefits, claims, and other inquiries or complaints and assist consumers, family members and stakeholders in a manner that resolves their inquiry, including the ability to respond to those with limited English proficiency or the hearing impaired.

- 3.4.11.3. Log all calls and arrange for appropriate follow-up, including notification of the consumer of the resolution consistent with the requirements specified in the PIHP and the State-funded contracts.
- 3.4.11.4. The RSNs shall train customer services staff to distinguish between a complaint, Third Party Insurance issue, Appeals and Grievances, information requests and how to triage these to the appropriate party. Call logs shall at a minimum track date of call, type of call, and resolution.

#### **3.4.12. Customer Service Questions (MSR)**

- 3.4.12.1. Describe how customer services calls will be answered during business hours. Will there be an automated attendant? If yes, how many choices will the caller offered (i.e., potential buttons to press) before speaking with a staff member? Discuss how consumer services staff will handle urgent and emergent calls that need to be directed to a crisis line or care manager.
- 3.4.12.2. Discuss the required qualifications of staff that will be providing ~~consumer~~ customer services (i.e., degree, type of experience, and years of experience).
- 3.4.12.3. Describe how requests from individuals with limited English proficiency and the hard of hearing will be handled.
- 3.4.12.4. Provide information on the expected frequency of contacts by enrollees or others, and a rationale for the staffing plan to provide this service.
- 3.4.12.5. Describe the procedures the Bidder will have in place to monitor the performance of customer services staff (e.g., live call monitoring, telephone statistics, etc.).
- 3.4.12.6. If any of these requirements will be delegated, describe the scope of the delegated function(s) or process(es); provide copies of subcontracts with the delegated entity; and address how the Bidder will provide oversight of the delegated entity. Customer Services must not be delegated to an entity contracted with the Bidder to provide community mental health services.
- 3.4.12.7. Describe how the Bidder will measure and report outcomes for these requirements.

### **3.5. Quality Requirements**

#### **3.5.1. Eligibility Verification and Determination Requirements**

- 3.5.1.1. DSHS shall determine eligibility for Title XIX services and provide eligibility data to the RSN.
- 3.5.1.2. The RSN must have processes to verify eligibility for Title XIX and to determine eligibility for State-funded services.
- 3.5.1.3. The RSN must have a subcontract or agreement that outlines deliverables for any delegated functions. The RSN must demonstrate how delegated functions will be monitored.

#### **3.5.2. Eligibility Verification And Determination Questions (~~MR~~ MSR)**

- 3.5.2.1. Describe in detail the process that will be used for verifying Medicaid eligibility for Title XIX waiver services. Include proposed samples of any documentation that will be used in the consumer record.
- 3.5.2.2. Describe in detail the process that will be used to determine the amount and duration and scope of State-funded mental health services that will be offered when an individual requests services, this must include the decision points used for providing any of the State-funded services including financial resources review. Include samples of any documentation used in the consumer record.

#### **3.5.3. Clinical Guideline Requirements**

The RSN's care management program shall adopt and disseminate both Clinical Practice Guidelines and Level of Care Guidelines. Access to Care Standards shall be used to authorize care based on medical necessity. Level of Care Guidelines shall be used to determine continuation and discharge following an exhaustion of initial authorization period. Clinical Practice Guidelines are distinct from Level of Care Guidelines and describe treatment protocols that are evidenced-based (e.g., has a preponderance of research-based evidence demonstrating their utility in driving positive clinical outcomes). An example of a Clinical Practice Guideline would be depression treatment guidelines. The RSN's care management program shall authorize care using both Access to Care Standards and Level of Care Guidelines and, where available, Clinical Practice Guidelines that meet the following professional standards:

- 3.5.3.1. Levels of Care (LOC) Guidelines are based on published or peer reviewed standards. The RSN shall also incorporate the MHD's Access to Care Standards (4-07-03) in the guidelines, including the

eligibility criteria for enrollee access to outpatient mental health services. Guidelines must include continuing stay and discharge criteria. The RSN must define the benefit period or length of stay and the intensity of service available for each treatment modality.

3.5.3.2. The RSN must adopt and disseminate at least two Clinical Practice Guidelines that are:

- 3.5.3.2.1. Based on valid and reliable research-based clinical evidence demonstrating their utility in driving positive clinical outcomes or reflecting promising practices.
- 3.5.3.2.2. Reflect a consensus of national mental health professionals.
- 3.5.3.2.3. Are adopted in consultation with mental health professionals in the contracted network of CMHAs, when applicable.
- 3.5.3.2.4. Are reviewed and updated biennially.
- 3.5.3.2.5. Are disseminated to all affected providers and, upon request, to enrollees.
- 3.5.3.2.6. Are applied in the administration of utilization management protocols, enrollee education and provider training.

3.5.4. **Clinical Guideline Questions (MR MSR)**

- 3.5.4.1. Provide a copy of the proposed Level of Care Guidelines that address the requirements above.
- 3.5.4.2. Provide a copy of the proposed Clinical Practice Guidelines that will be adopted and implemented and the source (e.g., adopted APA published guideline for depression treatment, developed internally).
- 3.5.4.3. For any guideline that is not planned to be adopted in full from a nationally recognized source, provide any supporting documentation to reflect that it is evidenced-based, research-based, and consensus-based or a promising practice and briefly describe the development of the Practice Guideline.
- 3.5.4.4. Describe steps the Bidder will take to disseminate and apply each Clinical Practice Guideline listed above.

### **3.5.5. Provider Network Requirements**

- 3.5.5.1. The RSN shall have a provider network for both Title XIX and State-funded services for each Service Area proposed. The network shall be based on a continuous analysis of need. The RSN shall develop an annual network management plan.
- 3.5.5.2. The network must be sufficient in size, scope and types of providers to offer all Title XIX and State-funded program, covered mental health services required by this RFP and fulfill all the service delivery requirements contained within the, attached PIHP and State-funded Contracts (Exhibits B and C) and State law. The RSN shall, at a minimum, consider the following factors in establishing the network:
  - 3.5.5.2.1. Current and anticipated Title XIX eligibles.
  - 3.5.5.2.2. Current and anticipated Title XIX mental health enrollment data.
  - 3.5.5.2.3. Current and anticipated State-funded data on eligibility and enrollment.
  - 3.5.5.2.4. Current and anticipated utilization of services.
  - 3.5.5.2.5. Cultural needs of mental health services recipients.
  - 3.5.5.2.6. Number of CMHAs who are not accepting new persons.
  - 3.5.5.2.7. Geographic location of providers, considering distance, travel time, the available transportation and whether the location provides physical access for persons with disabilities.
  - 3.5.5.2.8. Prevalent language(s), including sign language, spoken by populations in the regional Service Area.
  - 3.5.5.2.9. Quality management data, including but not limited to appointment standards data, and problem resolution.
  - 3.5.5.2.10. Client Satisfaction Surveys.
  - 3.5.5.2.11. Compliant, grievance and appeal data.

- 3.5.5.2.12. Reports of issues, concerns, or requests initiated by other State agencies that have involvement with persons covered under this RFP.
- 3.5.5.2.13. Other demographic data.
- 3.5.5.3. The network must have a sufficient number of provider types or services to:
  - 3.5.5.3.1. To ensure a sufficient number, mix, and geographic distribution of community mental health agencies (CMHAs) including mental health care providers (MHCPs) to meet:
    - 3.5.5.3.1.1. An age appropriate range of mental health services for children, adolescents, adults and older adults.
    - 3.5.5.3.1.2. A culturally-competent range of services to meet the needs of special populations.
    - 3.5.5.3.1.3. Access to medically necessary mental health services to meet the needs of the anticipated number of enrollees.
  - 3.5.5.3.2. To ensure enrollee choice of at least two Mental Health Care Providers (MHCP) for each level of care and/or population (adult/child). An enrollee who has received authorization from the RSN for referral to a network hospital for community inpatient care shall be allowed to choose from among all the available hospitals within the region, to the extent reasonable and appropriate.
- 3.5.5.4. The RSN must be available to respond to referral and authorization requests 24 hours per day, 7 days per week.
- 3.5.5.5. The RSN must provide access to treatment within the following standards:
  - 3.5.5.5.1. Immediate/Emergent: within two hours of the request for service
  - 3.5.5.5.2. Urgent: within 24 hours of the initial request for service
  - 3.5.5.5.3. Intake: within 10 days of the initial request for services for Medicaid enrollees.
  - 3.5.5.5.4. Authorization: within 14 days of the initial request for services

- 3.5.5.5.5. Routine: within 14 days of authorization not to exceed 28 days from the initial request for services
- 3.5.5.6. The network must be geographically accessible to the Service Area served by the RSN and the RSN must ensure that, when enrollees must travel to service sites, they are accessible per the following standards:
  - 3.5.5.6.1. In rural areas, service sites are within a 30-minute commute time.
  - 3.5.5.6.2. In large rural geographical areas, service sites are accessible within a 90-minute commute time.
  - 3.5.5.6.3. In urban areas, service sites are accessible by public transportation with the total trip including transfers, scheduled not to exceed 90 minutes each way.
  - 3.5.5.6.4. These travel standards do not apply for psychiatric inpatient services when the enrollee chooses to use comparable service sites that require travel beyond the travel standards, or for exceptional circumstances (e.g., inclement weather, hazardous road conditions due to accidents or road construction, public transportation shortages, delayed ferry service).
- 3.5.5.7. The RSN must provide services, including crisis telephone services, in the person's primary or preferred language. Interpreters, whenever possible, should have training in mental health terminology to provide the person with assistance in describing the signs and symptoms of mental illness and protect the person's confidentiality.
- 3.5.5.8. The RSN must ensure that adolescent consumers reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in service providers.
- 3.5.5.9. The RSN must allow children and parents to choose to receive services from the same provider when appropriate.
- 3.5.5.10. The RSN must recruit consumers and family members as certified peer counselors or to provide other services.

### 3.5.6. Provider Network Questions (MSR)

- 3.5.6.1. Describe the needs analysis process the Bidder will use to determine network adequacy for children, adolescents, adults, older adults and special populations.
- 3.5.6.2. Provide a copy of the Bidders proposed network management plan, Discuss in detail how age, gender, and cultural needs of the population are addressed in the plan.
- 3.5.6.3. Indicate the unduplicated number of beds the Bidder is proposing for the network in each of the following breakouts. Include beds expected to be within the contracted Service Area and outside the contracted Service Area. Count each bed only once and include only those for which there will be formal written agreements or that will be operated by the Bidder:

<b>Types of Residential Facilities</b>	<b>Number of Beds in Service Area</b>	<b>Number of Beds Outside the Service Area</b>
Crisis (including respite and stabilization beds)		
Long Term Psychiatric Rehabilitation (e.g. Adult Residential Rehabilitation Centers)		
Supervised Living (on site staffing 24/7, e.g. boarding homes, Adult Family Homes)		
Supported Housing (on site staffing less than 24/7, unlicensed individual or group settings)		
Other (Specify)		

<b>Inpatient Services</b>	<b>Number of Beds in Service Area</b>	<b>Number of Beds Outside the Service Area</b>
Community Hospital/Evaluation and Treatment Facilities		
Other (Specify)		
Total Count		

- 3.5.6.4. Describe the needs analysis process the Bidder will use to determine network adequacy for types of residential beds and inpatient services.

- 3.5.6.5. Provide the following information for Clubhouses that will participate in the network:

Clubhouse Name & Address	Hours of Operation

- 3.5.6.6. Provide a geo-access calculation reporting the distance of potential providers to consumers by zip code; as an alternative, list the number and type of potential providers (e.g., CMHA, hospital, clubhouse) and the number of consumers by zip code. Identify zip codes that do not meet the access standards identified in the Provider Network Requirements Section and discuss: 1) barriers to locating or contracting with providers in areas that do not meet the access standards; and (2) strategies to expand provider coverage in those areas.
- 3.5.6.7. Describe the Bidder's approach to recruiting and tracking the availability of an adequate number of providers to deliver services, including crisis telephone services, in the person's primary or preferred language. Discuss how the availability of qualified interpreters is monitored.
- 3.5.6.8. Describe how consumers and family members will be recruited as peer support providers or to provide other services.
- 3.5.6.9. Describe how the Bidder will ensure that adolescent consumers reaching the age of majority are provided continuity of care without service disruptions or mandatory changes in service providers.
- 3.5.6.10. Describe how the Bidder will facilitate access to the same CMHA or provider for children and parents when appropriate.

### 3.5.7. Care Management Requirements

- 3.5.7.1. For the purposes of this RFP, care management pertains to a set of clinical management oversight functions that shall be performed by the RSN. Care management focuses on access, referrals, oversight of care coordination, utilization review, resource management, risk management, and quality improvement. Resource management functions are part of care management. The goals of care management are to promote access to appropriate services; to continuously improve quality of care; and to manage resources efficiently. Care management functions are distinct from case management services and may not be delegated to a network CMHA.

3.5.7.2. The RSN shall have a psychiatric medical director (subcontracted or staff) and sufficient care managers to carry out essential care management functions including provision of:

- 3.5.7.2.1. The planning, coordination, and authorization of residential services and community support services, including authorization for intake evaluation.
- 3.5.7.2.2. The planning, coordination, and authorization for Mental Health treatment for children eligible under the federal Title XIX Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program.
- 3.5.7.2.3. Ensure the availability of crisis plan and provider of record 7 days a week, 24 hours a day to Designated Mental Health Professionals (DMHPs), evaluation and treatment facilities, and others as determined by the RSN.
- 3.5.7.2.4. Authorization 24 hours a day, 7 days a week for voluntary community inpatient hospitalization. Authorizations must occur within 12 hours of the request.
- 3.5.7.2.5. Utilization management including review of requested services against medical necessity criteria, authorization of necessary care, and administration of denials and appeals including access to expedited appeals.
- 3.5.7.2.6. Review of assessment and treatment services against clinical practice standards. Standards of practice include, but are not limited to, evidenced based practice guidelines, discharge planning guidelines, and community standards governing activities such as coordination of care among treating professionals and other consumer serving agencies.
- 3.5.7.2.7. Risk Management, including high risk case tracking and follow-up and tracking compliance with 7- and 30-day outpatient follow-up appointments for consumers discharged from inpatient care.

**3.5.8. Care Management Questions (MSR)**

- 3.5.8.1. Provide a narrative description of how the care management functions listed in the previous section will be organized and staffed.

- 3.5.8.2. Provide an organizational chart for care management functions that includes number of staff in full time equivalents (FTE) by staff category and primary reporting relationships. Provide a rationale for the staffing plan.
- 3.5.8.3. Discuss the role that will be played by the psychiatric medical director, include hours of availability to the Bidder and availability of the medical director and other psychiatrists to review inpatient care authorization/denials and complex clinical issues.
- 3.5.8.4. Describe the qualifications of staff that will be performing care management functions, including the staff who will answer the Care Management line. Include minimum degree and years of experience requirements for staff in each category.
- 3.5.8.5. Describe the initial orientation and ongoing training protocols that will be in place for care management staff.
- 3.5.8.6. Describe the Bidders protocols that will be in place for monitoring the performance of care management staff, including live call monitoring, documentation audits, caseload reports, etc.
- 3.5.8.7. Describe how the Bidder will measure and report outcomes for the requirements.
- 3.5.8.8. If any of these requirements will be delegated, describe the scope of the delegated function(s) or process(es); provide copies of the subcontracts with the delegated entity; and address how the Bidder will provide oversight of the delegated entity.

### **3.5.9. Access Requirements**

The RSN shall:

- 3.5.9.1. Provide access to telephonic assessment and referral services provided by appropriately qualified care management staff via ~~both local and a toll free number.~~ In addition local numbers may be provided for individuals in the local area.
- ~~3.5.9.2. Answer calls within five (5) rings, with an average speed of answer of 30 seconds, and a call abandonment rate of less than three (3) percent.~~
- 3.5.9.3. Arrange for access to emergent crisis services 24 hours per day, 7 days per week.

- 3.5.9.4. Arrange for access to urgent services within 24 hours of a request for services.
- 3.5.9.5. Arrange for an intake evaluation for routine services within 10 business days of a request for services.
- 3.5.9.6. Persons eligible for State-funded mental health services shall receive an intake evaluation based on assessment of need and available resources.
- 3.5.9.7. Track the Care Management access and referral line, including the volume of calls, call responsiveness statistics, and number of referrals by category of service.
- 3.5.9.8. Have methods to monitor compliance with access requirements, including:
  - 3.5.9.8.1. Number of Title XIX eligible persons who request services.
  - 3.5.9.8.2. Number of Title XIX eligible persons who receive an intake.
  - 3.5.9.8.3. Number of persons who meet medical necessity for Title XIX services.
  - 3.5.9.8.4. Number of Title XIX persons who meet medical necessity criteria and are referred to Title XIX or waiver services, following intake.
  - 3.5.9.8.5. Number of persons who request State-funded mental health services.
  - 3.5.9.8.6. Number of persons who are authorized for State-funded mental health services.
  - 3.5.9.8.7. Length of time between the initial request and first offered appointment for an intake evaluation and length of time between the intake and first routine follow-up appointment.
  - 3.5.9.8.8. Availability of crisis services 24 hours a day, 7 days a week, including access to Designated Mental Health Professionals for Involuntary Treatment evaluations.

### **3.5.10. Access Questions (MSR)**

- 3.5.10.1. Describe the process that will be in place for scheduling and authorizing ~~authorization~~ for intake evaluations and referrals of Title XIX persons. Provide a flow chart of the processes.
- 3.5.10.2. Describe the referral process that will be in place for intake evaluation and authorization for State-funded mental health services. Provide a flowchart of the processes.
- 3.5.10.3. Will the Care Management Line have an automated attendant? If yes, how many choices is the caller offered (i.e., potential buttons to press) before speaking with a staff member?
- 3.5.10.4. Describe how the Bidder will provide oversight of the intake process, including reports on intakes and referrals and protocols for monitoring the performance of access and referral staff (e.g., live call monitoring).
- 3.5.10.5. Describe how emergency calls to the Bidder will be handled after business hours and how staff will transfer crisis calls to the crisis program without losing contact with the caller.
- 3.5.10.6. Will the Bidders clinical staff be available on-site to Care Management staff or via pager or telephone during business hours? What will be in place to monitor the availability of Care Management staff?
- 3.5.10.7. Describe what clinical back-up will be available to the Care Management staff (e.g., for supervisory or medical consultation).
- 3.5.10.8. Describe how the Bidder will measure and report outcomes for the requirements.

### **3.5.11. Authorization and Utilization Management Requirements**

- 3.5.11.1. The RSN Care Management system shall have a unified method of authorization and utilization management for title XIX and State-funded Services. ~~Authorization and utilization management shall be provided by the RSN; these functions may not be delegated.~~ Authorization and utilization management functions may not be delegated to a network CMHA.
- 3.5.11.2. The RSN must have a process for the determination of medically necessary mental health services by a Mental Health Professional.

- 3.5.11.3. The RSN must have a process for review of treatment plan to:
  - 3.5.11.3.1. Ensure it meets the needs of the individual.
  - 3.5.11.3.2. Is consistent with Level of Care and applicable Clinical Practice Guidelines.
  - 3.5.11.3.3. Includes consumer participation in the treatment planning process.
  - 3.5.11.3.4. Involves family members, when appropriate, in the evaluations and service planning processes.
  - 3.5.11.3.5. Includes input from other health, schools, social service, and justice agencies, as appropriate and consistent with privacy requirements.
- 3.5.11.4. The RSN must have a process for authorization of care following:
  - 3.5.11.4.1. Intake assessment
  - 3.5.11.4.2. Utilization review for continuing stay
- 3.5.11.5. The RSN must have a process for review by a licensed, Board-certified psychiatrist of pending denials of inpatient care prior to issuing the denial.
- 3.5.11.6. The RSN's policies and procedures for issuing a service denial must include:
  - 3.5.11.6.1. Timeliness of notification.
  - 3.5.11.6.2. Verbal and written notification.
  - 3.5.11.6.3. Notification of appeal rights.
  - 3.5.11.6.4. Review of all denials of all community inpatient services by a licensed, Board-certified psychiatrist.
- 3.5.11.7. The RSN's policies and procedures for conducting appeals must include: Physician review of all inpatient appeals and a MHP review of all other appeals.
- 3.5.11.8. The RSN shall have a written Utilization Management (UM) Plan that is consistent with federal requirements and which includes

mechanisms to detect under utilization as well as over utilization of services.

3.5.11.8.1. UM Plan must address historical use of resources, projections of future need, and clinical management goals. Clinical management goals include the substitution of evidence-based, consensus-based, or promising practices, or other services that impact the use of high cost inpatient care by assisting the enrollee with recovery and symptom management.

3.5.11.8.2. The UM Plan shall have separate sections for Title XIX resources and State resources. The RSN shall actively monitor and analyze utilization and cost data for covered services by provider and program type.

3.5.11.9. The RSN shall have a routine process for comparing actual utilization to the UM Plan. The goals of this comparison are to assess how funds are utilized, to identify clinical interventions that may reduce inappropriate use of high cost services, and to track the availability of Title XIX and State resources throughout the contracts period of performance.

### 3.5.12. **Authorization And Utilization Management Questions (MSR)**

Provide a written description that may include policies and procedures that address the process to determine medically necessary mental health services and authorization of care. At a minimum, address the following:

3.5.12.1. Which services will require prior authorization?

3.5.12.2. Protocols for concurrent review **for each level of care**. Include in the description:

3.5.12.2.1. Whether reviews are paper-based, telephonic, or utilize on-line technologies or electronic submission of required review information.

3.5.12.2.2. Type of information collected during the review process?

3.5.12.2.3. Triggers for a review (acuity, diagnosis, number of days, etc.).

3.5.12.2.4. How the will select cases for outpatient concurrent review, including a description of any clinical algorithms and/or

automated technologies that allow for streamlined administration of the outpatient review process.

- 3.5.12.3. Describe how the Bidder will ensure consistent application of review criteria for authorization and continued stay decisions. At a minimum, describe the Bidders protocols that will be in place for monitoring utilization management decisions to ensure inter-rater reliability across reviewers:
  - 3.5.12.3.1. Provide copies of formal tools that will be used for monitoring purposes.
  - 3.5.12.3.2. Describe how cases will be selected for monitoring review.
  - 3.5.12.3.3. Indicate the expected frequency and volume of reviews for each Care Manager.
  - 3.5.12.3.4. Indicate who will conduct the monitoring activities, and how the monitoring team will be trained to conduct these reviews.
  - 3.5.12.3.5. Describe how feedback will be summarized and provided to reviewers, including corrective actions, if indicated.
- 3.5.12.4. Referrals to psychiatrists or senior clinicians for review of authorization decisions for reasons other than issues of medical necessity. For example, the Care Manager may have questions about the diagnosis and relevance of the proposed treatment. Include at a minimum, the list of reasons for referral and the process for referral and completion of the consult. The process should include a description of how cases are selected for senior clinician review, information that is presented to the clinician, documentation requirements following the consult and how the Bidder will ensure that recommendations are implemented during the care management process.
- 3.5.12.5. How will consumers be notified of the services for which they are eligible and how the Bidder will facilitate the following:
  - 3.5.12.5.1. Notification of the consumer of their determined level of care, how medical necessity was determined, and the services available within that level of care.
  - 3.5.12.5.2. Consumer participation in decisions concerning their treatment options.
  - 3.5.12.5.3. Consumer choice of services and MHCPs.

- 3.5.12.6. Provide a copy of the proposed UM Plan describing the Bidders projected use of resources, how UM decisions will be made including utilization monitoring activities, and UM reporting.
- 3.5.12.7. Provide copies of sample reports that may be used in UM planning.
- 3.5.12.8. Provide samples of expected typical UM activities or actions.
- 3.5.12.9. Describe how the Bidder will measure and report outcomes for the requirements.
- 3.5.12.10. If any of these requirements are intended to be delegated, describe the scope of the delegated function(s) or process(es); provide copies of the subcontracts with the delegated entity; and address how the RSN will provide oversight of the delegated entity.

**3.5.13. Grievance System - Appeals, Grievances and Fair Hearings Requirements**

The RSN shall operate a Grievance System, which shall include a process to appeal a notice of action **for Title XIX only**, a grievance process and access to the State's fair hearing process that meets standards of Washington Administrative Code (WAC) 388-865-0255 and 42 CFR 438 Subpart F, including:

- 3.5.13.1. A grievance process, an appeal process, and access to the State's fair hearing process.
- 3.5.13.2. Monitoring to verify that the grievance system is used consistently throughout the entire Service Area.
- 3.5.13.3. Allowance for a representative of the consumer to assist or act on their behalf in filing and pursuing complaints, grievances, and fair hearings if the requested by the consumer.
- 3.5.13.4. Provisions for consumer access to Ombuds services to assist in addressing complaints, grievances, appeals and fair hearings.
- 3.5.13.5. Protocols for issuing a service denial, including requirements governing:
  - 3.5.13.5.1. Basis of determination of decisions
  - 3.5.13.5.2. Timeliness of notification of decisions
  - 3.5.13.5.3. Verbal and written notification.

- 3.5.13.5.4. Notification of rights specific to Title XIX and State-funded programs under WAC 388-865-0410.
- 3.5.13.5.5. Review of all denials of inpatient services by a licensed, Board-certified psychiatrist.
- 3.5.13.6. A process for conducting appeals.
- 3.5.13.7. Qualified clinicians who can conduct appeals; minimum requirement for MHP.
- 3.5.13.8. Notice that a consumer or his or her representative may request a State Fair Hearing within 20 days of notice of disposition of an appeal, for Title XIX, or a grievance.
- 3.5.13.9. Notice that a consumer may also file a request for a Fair Hearing at any time if he/she believes there has been a violation of the Washington Administrative Code.
- 3.5.14. **Grievance System - Appeals, Grievances and Fair Hearings Questions (MSR)**
  - 3.5.14.1. Provide a written description that may include policies and procedures ~~and a narrative description~~ that addresses the Grievance System which includes an appeals process, for Title XIX enrollees and grievance and fair hearing process for all consumers including:
    - 3.5.14.1.1. The system a will be in place that includes a grievance process, an appeal process, and access to a State Fair Hearing.
    - 3.5.14.1.2. The grievance system that will be used consistently through the entire Service Area.
    - 3.5.14.1.3. Allowances for a representative of the consumer to act on his or her behalf in filing and pursuing complaints, grievances, appeals and Fair Hearings at the consumer's request.
    - 3.5.14.1.4. Provisions for consumer access to Ombuds services to assist in addressing complaints, grievances appeals and fair hearings.

3.5.14.2. Provide a written description that may include written policies and procedures ~~and a narrative description~~ that addresses the Bidders expected protocols for issuing a service denial, including requirements governing:

3.5.14.2.1. Basis for the determination

3.5.14.2.2. Timeliness of notification of decision.

3.5.14.2.3. Verbal and written notification.

3.5.14.2.4. Notification of rights specific to Title XIX and State-funded programs under WAC 388-865-0410

3.5.14.2.5. Review of all denials of inpatient services by a licensed, Board-certified psychiatrist.

3.5.14.3. Provide a written description that may include written policies and procedures ~~and a narrative description~~ that addresses the Bidders expected appeals process.

3.5.14.4. Discuss the qualifications of clinicians who will conduct appeals.

3.5.14.5. Describe how the Bidder will provide notice that a consumer or his or her representative may request a Fair Hearing within 20 days of notice of disposition of a grievance or appeal, for Title XIX, by a PIHP if the disposition is not favorable to the consumer. Describe how a consumer will be notified of the right to file a request for a Fair Hearing at any time if the consumer believes there has been a violation of the Washington Administrative Code.

3.5.14.6. Describe how the Bidder will measure and report outcomes for the requirements.

### 3.5.15. **Care Coordination Requirements**

The RSN's shall provide the following care coordination activities:

3.5.15.1. **Early and Periodic Screening, Diagnosis and Treatment (EPSDT):** Arrange for medically necessary mental health services for children under 21 eligible for EPSDT, Medicaid's preventative health screening program for children under the age of 21. The RSN shall incorporate the following requirements into its care management, network management, and quality management activities:

- 3.5.15.1.1. Provide a mental health intake evaluation by a qualified children's mental health specialist.
- 3.5.15.1.2. Implement criteria for determining the appropriate level of medically necessary services in accord with the following levels from the Access to Care Standards:
  - 3.5.15.1.2.1. Level I Services: Children who have a minimal need for services will be referred to Level I services or multiple agency services.
  - 3.5.15.1.2.2. Level II Services: Children who are priority population children, in need of intensive services and involved with more than one service system, will be referred to Level II for comprehensive children's mental health services. Level II services consist of longer term intensive community-based options, integrated across all services.
  - 3.5.15.1.2.3. Provide EPSDT care/resource managers to promote access to EPDST funded mental health services; to coordinate care between physicians and mental health professionals, and juvenile justice, K - 12 education child welfare staff, and foster care regarding EPSDT services; and to reduce fragmentation and duplication of efforts among child serving systems; and to control costs.
- 3.5.15.2. **High Risk Consumers:** Monitoring follow-up activities of the CMHA or MHCP for high risk consumers who do not appear for scheduled appointments; for individuals for whom a crisis services has been provided as the first service in order to facilitate engagement with ongoing care; and for individuals discharged from 24-hour care in order to facilitate engagement in ongoing care following discharge.
- 3.5.15.3. **Frequent Users of Crisis, Emergency Room and Inpatient Services:** Provide intensive care coordination for consumers who are frequent users of crisis services, the emergency room or have more than one inpatient or evaluation and treatment admission within 60 days. Intensive care coordination includes, for example, increased oversight of clinical intervention strategies and/or the inpatient setting to community transition plan.
- 3.5.15.4. **Primary Care and Emergency Room:** Coordination of care with each enrollee's primary care provider (PCP) and emergency rooms

utilized by consumers. If the individual does not have a source of primary care, provide them assistance in accessing primary care.

3.5.15.5. **Special Populations:** Coordination of care for the following special populations as identified in WAC 388-865-0150:

3.5.15.5.1. Children

3.5.15.5.2. Older adults

3.5.15.5.3. Ethnic minorities

3.5.15.5.4. Persons with disabilities in addition to mental illness.

3.5.15.6. **Inpatient and Community Care:** Oversight of the coordination of psychiatric hospital and evaluation and treatment facility admissions and discharges, including discharge planning that meet the following requirements:

3.5.15.6.1. Implement mechanisms that promote rapid and successful reintegration of consumers to the community from hospitals and evaluation and treatment facilities. The RSN must monitor these mechanisms for effectiveness and demonstrate how the monitoring activities are used to promote continuity of care and quality improvement in the service delivery.

3.5.15.6.2. Maintain an In-Residence Census (IRC) in the State Hospital facilities not to exceed the capacity funded by the legislature, and computed for the RSN by DSHS.

3.5.15.6.3. Assure contact with staff occurs within 3 working days of a voluntary or involuntary admission and participation in treatment and discharge planning with the staff, includes:

3.5.15.6.3.1. Participation throughout the admission to assist with appropriate and timely discharge for all individuals regardless of diagnosis.

3.5.15.6.3.2. Coordination with staff to develop appropriate community placement and treatment service plans.

3.5.15.6.3.3. Designation of a CMHA that has the primary responsibility to coordinate outpatient and residential services to be provided to the individual based on medical necessity and available resources. The

assigned CMHA must offer, at minimum, one follow-up service within 7 days from discharge and one follow-up service within 30 days of discharge.

- 3.5.15.6.4. Monitor for effectiveness of the above activities and demonstrate how the monitoring is used to promote continuity of care and quality improvement in the service delivery.
- 3.5.15.6.5. Respond to State hospital census alert notifications by using best efforts to divert State psychiatric hospital admissions and expediting discharges from the State psychiatric hospital using alternative community resources and mental health services.
- 3.5.15.6.6. The RSN must respond to requests for monitoring, authorization, coordination and ensuring provision of medically necessary mental health outpatient services to individuals who are:
  - 3.5.15.6.6.1. On a Less Restrictive Alternative court order in accordance with RCW 71.05.320
  - 3.5.15.6.6.2. On a Conditional Release under RCW 71.05.340
  - 3.5.15.6.6.3. On a Conditional Release under RCW 10.77.150

### **3.5.16. Care Coordination Questions (MSR)**

- 3.5.16.1. Provide a written description that may include written policies and procedures and a narrative description that addresses the Bidders approach to all of the requirements in the care coordination requirements in the previous section:
  - 3.5.16.1.1. EPSDT
  - 3.5.16.1.2. High Risk Consumers
  - 3.5.16.1.3. Frequent Users of Crisis, Emergency Room and Hospital or Evaluation and Treatment Services
  - 3.5.16.1.4. Primary Care and Emergency Room
  - 3.5.16.1.5. Special Populations
  - 3.5.16.1.6. Inpatient and Community Care

- 3.5.16.2. Describe how the Bidder will measure and report outcomes for the requirements.

**3.5.17. Quality Assurance/Performance Improvement Program Requirements**

- 3.5.17.1. The RSN shall have qualified and sufficient staff to support the quality management/performance improvement (QA/PI) activities identified in this section.

- 3.5.17.2. The RSN shall have one written, integrated Quality Assurance/Performance Improvement Program (QA/PI) that addresses Title XIX and State-funded programs.

- 3.5.17.2.1. The QA/PI program shall have a system to collect data, conduct monitoring, verify services and review its ongoing quality management program to monitor the assessment of, and improvements to, the quality of public mental health services in their Service Area and to determine the effectiveness of the overall regional system of care.

- 3.5.17.2.2. For Title XIX services, the RSN shall establish and maintain a written program for a QA/PI consistent with federal 42 CFR 434.34 and 42 CFR 438.240 and with the utilization control program as described in 42 CFR 456.

- 3.5.17.2.3. For State-funded services, the RSN shall establish and maintain a written program for QA/PI. These documents shall comprise the QA/PI Plan.

- 3.5.17.3. The RSN shall meet, or exceed, MHD defined minimum performance levels on the standardized performance indicators listed below:

- 3.5.17.3.1. Time from the initiation of an intake evaluation to first non-crisis appointment shall not exceed 14 days.

- 3.5.17.3.2. State Hospital Bed Utilization shall not exceed the RSN allocation defined in Exhibit E.

- 3.5.17.3.3. Outpatient Services must be provided within 7 days following a hospital discharge.

- 3.5.17.3.4. Other performance indicators will be developed as part of the final contract. These may include Medicaid Penetration

Rate and Consumer Outcome Surveys (Telesage). The Bidder is not expected to provide a response related to these additional indicators as part of the proposal.

- 3.5.17.4. The RSN must incorporate the analysis of performance indicator results into quality improvement activities.
- 3.5.17.5. The RSN must develop and implement four performance improvement projects two clinical and two non-clinical using data from multiple sources that focus on clinical and non-clinical areas. These projects must achieve, through ongoing measurements and interventions, demonstrable and sustained improvement in significant aspects of care that can be expected to have a favorable effect on mental health outcomes and enrollee satisfaction.
- 3.5.17.6. The RSN must measure provider performance through medical record audits.
- 3.5.17.7. The RSN must provide performance feedback to providers, including detailed discussion of clinical standards and expectations of the RSN.
- 3.5.17.8. The RSN must participate in an External Quality Review authorized by DSHS.
- 3.5.17.9. The RSN shall maintain an active QA/PI committee that coordinates with the RSN Quality Review Teams described in WAC 388-865-0282, which shall be responsible for carrying out the planned activities of the QM/PI program. This committee shall have regular meetings, shall document participation by providers, and shall be accountable and report regularly to the governing board. The RSN shall maintain records documenting the committee's findings, recommendations, and actions. The committee shall address both Title XIX and State-funded services. At a minimum, the RSN's psychiatric medical director shall consult to the QA/PI committee and assist with setting QA/PI goals.
- 3.5.17.10. The RSN shall designate a senior executive who shall be responsible for program implementation. The RSN's must ensure that a qualified Mental Health Professional shall have substantial involvement in the QA/PI program functions.
- 3.5.17.11. The QA/PI program shall integrate the results of activities such as, but not limited to, consumer satisfaction surveys; performance improvement projects (PIP); external quality reviews (EQR); and grievance and appeals data.

**3.5.18. Quality Assurance/Performance Improvement Program Questions (MSR)**

- 3.5.18.1. Provide the number and qualifications of staff who will be administering the QA/PI program and rationale for this staffing and qualifications. Include how this program fits within the Bidders organizational framework.
- 3.5.18.2. Provide a copy of the Bidders QA/PI plan that includes performance metrics monitored in the last 12 calendar months. Include the metric, targeted performance or goal, and actual performance against goal.
- 3.5.18.3. Describe what the composition of the QA/PI Committee will be Identify who chairs the committee and identify committee members by type of position (consumer representative, provider representative, etc.). Describe the roles of the psychiatric medical director and the Quality Review Team ( as required by WAC 388-865-0282) on the QA/PI Committee.
- 3.5.18.4. Describe how frequently the QA/PI committee will meet.
- 3.5.18.5. Provide copies of sample reports reviewed by the QA/PI Committee.
- 3.5.18.6. Provide sample minutes from recent QA/PI committee meetings that reflect the typical activities or actions by the committee.
- 3.5.18.7. Provide two examples of how the Bidder implemented quality improvement initiatives resulting from QA/PI activities prior to March 1, 2006.
- 3.5.18.8. Describe the process for integrating consumer satisfaction survey data into the QA/PI program.
- 3.5.18.9. Describe how the Bidder monitors clinical outcomes and utilizes results to measure program effectiveness.
- 3.5.18.10. Describe how the Bidder monitors provider performance, including the following items:
  - 3.5.18.10.1. The Bidders protocol for conducting site visits of providers, including clinical record reviews.

- 3.5.18.10.2. The Bidders protocol for profiling provider performance on cost, access, and quality, including what is measured and how results are used to provide feedback to providers on their performance.
- 3.5.18.10.3. Include a copy of a sample provider profiling report, if available.
- 3.5.18.10.4. Other methods for training or monitoring provider performance, including compliance with Clinical Practice Guidelines.
- 3.5.18.11. Describe how the Bidder will measure and meet the standardized performance indicators listed below:
  - 3.5.18.11.1. Time from the initiation of an intake evaluation to first non-crisis appointment shall not exceed 14 days.
  - 3.5.18.11.2. State Hospital Bed Utilization shall not exceed the RSN allocation.
  - 3.5.18.11.3. Outpatient Services must be provided within 7 days following a hospital discharge.
- 3.5.18.12. Describe how the Bidder will incorporate the analysis of performance indicator results into quality improvement activities.

**~~3.6. Transition, Implementation Plan and Start-Up Requirements~~**

- ~~3.6.1. A transition plan must be provided to demonstrate how the Bidder will be able to begin operation of its capitated services and be responsible for managing behavioral health services for all Medicaid enrollees and to arrange for or provide State-funded services for persons who meet State eligibility requirements by September 1, 2006.~~
- ~~3.6.2. The Bidder must appoint a project manager and meet with DSHS as requested to provide updates on progress towards implementation.~~

**~~3.7. Transition, Implementation Plan and Start-Up Questions~~**

- ~~3.7.1. The Contractor shall acknowledge that it will not receive compensation for the requirements to implement an operational organization during the start-up period.~~
- ~~3.7.2. The Contractor shall develop and provide to the DSHS for review and approval an Implementation Plan using project software that clearly~~

~~outlines a timetable for implementation from award of the contract to the date by which the Contractor will begin operation of its capitated services and be responsible for managing behavioral health services for all Medicaid enrollees and to arrange for or provide State-funded services for persons who meet State eligibility requirements. The chart must display key dates and events, the position and title of the responsible party for the events, and include the percentage of time allocated for all staff responsible for implementation. The dates and events must, at a minimum, relate to the key operational requirements, including transition from existing RSN operations. The Implementation Plan will also specifically identify and address each of the start-up requirements as discussed in the requirements of this section.~~

- ~~3.7.3. The Bidder must appoint a project manager and meet with DSHS as requested to provide updates on progress towards implementation.~~

**3.8. Factor for Additional Financial Resources: (Optional for bonus points)**

**3.8.1. Factor for Additional Resources Requirements**

The bidder may receive additional points for demonstrating they will contribute additional financial resources for the mental health services provided through this RFP beyond that provided by state appropriation or allocation. The additional financial resources must be under the direct financial control of the bidder and does not include financial resources under the financial control of a bidder's subcontractors.

- 3.8.1.1. Additional financial resources include the sales and use tax for chemical dependency or mental health treatment services or therapeutic courts authorized in RCW 82.14.460.

Additional financial resources may also include other monetary resources or revenues that the bidder has committed to the project such as county funds, federal grants (excluding the mental health federal block grant), or other contribution.

- 3.8.1.1.1. The bidder is required to provide sufficient narrative and budget detail to demonstrate to evaluators the real value of other additional financial resources which the bidder identifies in its response.
- 3.8.1.1.2. The bidder shall only receive consideration of the sales and use tax authorized by RCW 82.14.460 if they can document that the county has formally authorized the tax by the date of submission of the proposal.

- 3.8.1.1.2.1. The bidder shall receive credit if the tax has been authorized but the effective date is not until after submission of the proposal.
- 3.8.1.1.2.2. The bidder shall receive no credit for the tax if the tax has not been authorized but there are plans to vote on the tax after submission of the proposal

3.8.2. **Scoring Factor Questions**

- 3.8.2.1. Identify and provide evidence of the following:
- 3.8.2.2. Counties in the service area which have authorized the sales and use tax allowed by RCW 82.14.460.
- 3.8.2.3. Other types of additional financial resources that are committed by the bidder to provide the services described in this RFP. Provide sufficient narrative and budget detail to fully describe the estimated value of the additional financial resources as well as how they will be used to supplement the resources received through the state appropriation.

EXHIBIT A  
INFORMATION, CERTIFICATIONS AND ASSURANCES FORM  
STATE OF WASHINGTON  
DEPARTMENT OF SOCIAL AND HEALTH SERVICES  
CENTRAL CONTRACT SERVICES  
RFP #0634-202 E2SHB 1290 Procurement

Completion of this Information form is a mandatory requirement for contracting with the Washington Department of Social and Health Services (DSHS). The certifications and assurances contained herein are a required element of the proposal.

**Failure to submit this Information form or any applicable attachments with a proposal may result in a proposal being rejected as non-responsive.**

**Please Type or Print Legibly:**

Bidder Name:			
Bidder Address:			
Telephone:		Fax Number:	
Contact Person for the Bidder's proposal:			

Check the applicable box and complete the sections identified.

**Provide additional information on separate sheets as may be required in each section**

## Section A:

1. The Bidder's Federal Identification number is: \_\_\_\_\_
2. The Bidder's Washington Uniform Business Identifier (UBI) Number is:  
\_\_\_\_\_

To obtain a Washington UBI Number call 360-664-1400.

3. Bidders proposed Contract Manager:

Name:			
Work Address:			
Telephone:		Fax Number:	

4. Has the Bidder had a contract or work order terminated for default during the last five years?

☐ Yes      ☐ No

If yes, attach a signed statement describing the contract, the circumstances surrounding the termination, and the name, address and telephone number of the other party to the contract. DSHS will evaluate the facts and may, at its sole discretion, reject the Bidder's proposal on the ground of its past performance. For the purpose of this question, "termination for default" means notice was given to the Bidder to stop contract work due to nonperformance or poor performance, and the performance issue was either (a) not contested by the Bidder or (b) litigated, finding the Bidder in default.

5. The Bidder declares that all answers and statements made in the proposal are true and correct.
6. In preparing this Proposal, the Bidder and/or the Bidder's employees have not been assisted by any current or former DSHS employee whose duties relate (or did relate) to this procurement and who was assisting in other than his or her official, public capacity.
7. The Bidder acknowledges that DSHS will not reimburse the Bidder for any costs incurred in the preparation of this proposal. All proposals become the

property of DSHS, and the Bidder claims no proprietary right to the ideas, writings, items or samples.

8. The Bidder acknowledges that any contracts awarded as a result of this procurement will be modeled after the PIHP and State-funded Contracts included with this RFP.
9. The Bidder understands that, if selected to contract with DSHS, the Bidder will be required to comply with all applicable State and federal civil rights and other laws. Failure to so comply may result in contract termination. If requested by DSHS, the Bidder agrees to submit additional information about the nondiscrimination policies of the Bidder's organization in advance of or after the contract award.
10. The Bidder acknowledges that it must have a current Washington Business License prior to execution of a contract.

**Section B:**  
**Legal Structure of Bidder**

**The Bidder is:**

<input type="checkbox"/> Currently contracted as an RSN
<input type="checkbox"/> One or more Washington counties cooperating by Interlocal Agreement under RCW 39.34
<input type="checkbox"/> A Non-Profit Corporation as registered with the Washington Secretary of State

1. Is any Manager or Employee of the Bidder a past or current State of Washington employee?  

☐ Yes      ☐ No

If yes, list names, positions, and dates of employment with the State of Washington in an attachment to this form.
2. Is any employee of the Bidder who will perform work under a contract between the Bidder and DSHS a past or current State of Washington employee?  

☐ Yes      ☐ No

If yes, list names, positions, and dates of employment with the State of Washington in an attachment to this form.

3. I am authorized to bind the Bidder to a contract or the name and title of the individual who is authorized to bind the Bidder to a contract and who will be signing any contracts between DSHS and the Bidder is:

Name:	
Title:	

**Section C:**

1. By signing below, the Bidder authorizes DSHS to conduct a financial assessment and/or background check of the Bidder if DSHS considers such action necessary or advisable before contracting with the Bidder.
2. Under the penalties of perjury of the State of Washington, the undersigned affirms the truthfulness of the statements made herein. The undersigned certifies that the Bidder is now, and shall remain, in compliance with the certifications and assurances contained herein, and agrees that such compliance is a condition precedent to the award and continuation of any related contracts. The undersigned acknowledges the Bidder's obligation to notify DSHS of any changes in the statements, certifications and assurances made herein.

Signature		Date
Printed or Typed Name		
Title		

EXHIBIT D  
CHECKLIST FOR RESPONSIVENESS

- ☐ Proposal was submitted on or before 3:00 p.m. on the due date.
- ☐ Required numbers of copies were submitted.
- ☐ Proposal is placed in binders with tabs separating the major sections of the proposal. The five major sections shall include:
  - ☐ 3.1 System Improvement Initiatives
  - ☐ 3.2 Administrative and Financial Requirements
  - ☐ 3.3 Information System Requirements
  - ☐ 3.4 RSN Program Requirements
  - ☐ 3.5 Quality Requirements
  - ☐ 3.6 Transition Plan
- ☐ Proposal is placed in binders for each section with tabs separating the major sections and subsections of the proposal.
- ☐ Proposal is complete, i.e. the Bidder responded to all requirements.
- ☐ The proposal does not impose conditions that would modify the RFP.
- ☐ Letter of Submittal and Certifications and Assurances were signed by an individual authorized to bind the Bidder to a contractual relationship.